Maternal and Child Health Services
Title V Block Grant

State Narrative for South Dakota

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Copies of the assurances and certifications are provided as an attachment to this section. The originals are maintained in the State Maternal and Child (MCH) program's central office.

The MCH program further assures it will: (1) use funds only for the purposes specified; (2) identify and apply a fair method to allocate funds to groups and localities; (3) apply guidelines for appropriateness and frequency of referrals; (4) use funds only to carry out the purposes of this title; (5) publish charges for services, not impose charges for low income, and adjust charges for income and resources; and (6) at least every 2 years audit expenditures and submit a copy of the audit report to the Secretary.

An attachment is included in this section.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

State performance measures were developed based on the state's comprehensive needs assessment. The South Dakota Department of Health (DOH) made the FY 2008 MCH block grant available for public review and comment via the DOH website at www.state.sd.us/doh. A summary of the plan was put on the website on May 22, 2007 with comments due back to the DOH by July 2, 2007.
/2009/ The DOH made the FY 2009 MCH block grant available for public review and comment via the DOH website at http://doh.sd.gov/. A summary of the plan was put on the website on May 22, 2008 with comments due back to the DOH by July 1, 2008. //2009//
/2010/ The DOH made the FY 2010 MCH block grant available for public review and comment via the DOH website at http://doh.sd.gov/news. A summary of the plan was put on the website on May 11, 2009 with comments due back to the DOH by July 2, 2009. // 2010//
Information on how to obtain a complete copy of the application for review was also provided on the website. No comments were received. The MCH program interacts daily with the MCH population and related providers which allows the MCH program to respond to any identified areas of need and build those recommendations into the annual plan prior to the block grant being available for public review.

The MCH program works throughout the year with many different programs and stakeholders around the state including the Department of Social Service (DSS), Department of Human Services (DHS), Department of Education (DOE), Department of Public Safety (DPS), Department of Transportation (DOT), Delta Dental, Ronald McDonald Dental Care Mobile, HELP!

Line, respite care, Aberdeen Area Indian Health Services (IHS), Aberdeen Area Tribal Chairman's Health Board (AATCHB), Healthy Start directors, school nurses, University of South Dakota (USD) School of Medicine, and pediatric specialists. Through participation in these many different projects and meetings, the MCH program constantly receives informal public input on additional opportunities to collaborate and improve efforts to serve the maternal and child health population in South Dakota.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The South Dakota MCH five-year needs assessment provides an overview of the status of the priorities established by the MCH program as required by the Title V MCH Block Grant program. The following priority needs in South Dakota cross the four levels of the public health services pyramid:

• Reduce unintended pregnancies;
• Reduce infant mortality;
• Improve pregnancy outcomes;
• Reduce morbidity and mortality among children and adolescents;
• Improve adolescent health and reduce risk-taking behaviors (i.e., intentional and unintentional injuries, dietary habits, tobacco use, alcohol use, and other drug utilization);
• Improve the health of, and services for, children with special health care needs (CSHCN) through comprehensive services and support;
• Improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN;
• Improve state and local surveillance and data collection and evaluation capacity; and
• Reduce childhood obesity.

The priority setting process is an ongoing and evolving process. Systems development for women, infants, children, adolescents, and CSHCN is an integral part of the MCH planning process and includes working collaboratively with partners to analyze current programs and services, identify gaps in services, establish appropriate goals and objectives, and establish methods for monitoring and evaluation to ensure goals and objectives are met.

South Dakota is a sparsely populated state with only 9.9 people per square mile. South Dakota's population continues to migrate to the eastern part of the state. Over 13 percent (13.2%) of the population lives below 100% and 33.1% live below 200% of the federal poverty level. However, only 2.6% of South Dakota children are without health insurance. Two thirds of the state is designated as Primary Medical Care Health Professional Shortage Area (HPSA), 61 of the 66 are designated as Mental HPSA, and nearly one-third is a Dental HPSA.

Through collaborative efforts, the MCH program has accomplished the following:
• Expanded the newborn metabolic screening to include Biotinidase deficiency, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders, fatty acid oxidation disorders, organic acid disorders and cystic fibrosis;
• Increased voluntary newborn hearing screening from 73.2% in 2001 to 96.8% in 2007;
• Utilized the Ronald McDonald Dental care mobile to see over 4,000 children and provided a retail value of over $1.7 million of dental care;
• Established biannual meetings with Healthy Start directors from eight of the reservation areas to address prenatal care issues and transportation;
• Working with the AATCHB on a Centers for Disease Control and Prevention (CDC) Tribal Pregnancy Risk Assessment Monitoring System (PRAMS) survey; and
• Enacted several new state laws that will have a positive effect on the MCH population.

/2009/ Through collaborative efforts, the MCH program has accomplished the following:
• Expanded the newborn metabolic screening panel to include cystic fibrosis as a mandated screen for all newborns (now screening 28 of the American College of Medical Genetics (ACMG)

core panel of conditions);
• Achieved an average turn-around time of 5 days and 13 hours from birth to reporting of metabolic screening results;
• Added long term follow-up to the metabolic program to assure all children residing in South Dakota with a diagnosed metabolic disorder are getting appropriate care for their metabolic disorder;
• Utilized the Ronald McDonald Dental Care Mobile to see 6,077 children and provided a retail value of over $2.5 million of dental care;
• Continued biannual meetings with Healthy Start directors from eight of the reservation areas to address issues such as prenatal care, family planning, tobacco use, infant morality, and transportation;
• Working with the AATCHB on a CDC Tribal PRAMS survey;
• Providing HIV testing to women when they come in for pregnancy testing;
• Increased collection of height and weight data from South Dakota schools (currently obtain data from over 242 school for 42,289 children); and
• Provided support for two additional staff for the Healthy Start programs on the Pine Ridge and Rosebud reservations. //2009//

/2010/ Through collaborative efforts, the MCH program has accomplished the following:
• Increased voluntary newborn hearing screening from 73.2% in 2001 to 98% in 2008;
• Achieved an average turn-around time of 5 days and 10 hours from birth to reporting of metabolic screening results which is two hours faster than the previous year;
• Serving 119 children (1992-present) through the Long-Term Follow Up for the metabolic program to assure children are receiving appropriate care for their metabolic disorder;
• Utilized the Dakota Smiles Mobile Dental Program to see 7,309 children and provided a retail value of over $3 million in dental care;
• Held biannual meetings with Healthy Start directors from eight of the reservation areas to address such issues as prenatal care, family planning, tobacco use, fetal alcohol syndrome, infant mortality, and transportation;
• Worked with the AATCHB on a CDC Tribal PRAMS survey;
• Provided 298 rapid HIV testing to adolescents 19 years of age and younger that were at high risk due to lifestyles; continued to provide HIV testing for women when they come in for pregnancy tests;
• Provided support for two additional Healthy Start staff on the Pine Ridge and Rosebud reservations;
• Provided HPV vaccine to 3,221 adolescent girls aged 11 to 18 years;
• Provided influenza vaccines free-of-charge to 21,319 children aged 6 months to 18 years through Community Health Services/Public Health Alliance sites;
• Increased collection of height and weight data from South Dakota schools from 242 to 249 schools; obtained data on 37,028 students in these schools;
• Provided respite care to 1,432 children (985 families) with chronic medical conditions, developmental disabilities, and serious emotional disturbances;
• Sponsored outreach genetic clinics in two communities in South Dakota to decrease the travel miles and time for families to access these services; and
• Increased income eligibility up to 250% of the federal poverty level (FPL) with no family cost share for CSHCN. //2010//

One of the biggest challenges for South Dakota and the MCH program continues to be the disparities of the state's Native American population:
• 48.5% of Native American women received prenatal care in the first trimester vs. 73.9% for White women;
• 5-year median infant mortality rate (infant deaths per 1,000 live births) for Native Americans is 2.5 times higher than Whites;
• 39.9% of Native American women smoked during pregnancy vs. 23.5% for Whites;
• 48.6% of Native American students were overweight/at risk of overweight vs. 31.6% for White

students; and
• The birth rate for teens 18-19 years of age for Native Americans was 217.1 per 1,000 women 18-19 years of age vs. 47.1 for Whites.

III. State Overview

A. Overview

South Dakota is one of the least densely populated states in the nation with 754,844 people living within its 75,955 square miles -- an average population density of 9.9 people per square mile (2000 Census). Over half (34) of the state's 66 counties are classified as frontier (population density of less than six persons per square mile) while 29 counties are considered rural (population density of six or more persons per square mile but no population centers of 50,000 or more). Three counties are classified as urban (have a population center of 50,000 or more). Of the state's total population, 88.7 percent are White (of which 99.3% are White alone, not Hispanic or Latino), 9.0 percent are Native American and the remaining 2.3 percent are classified as some other race.

According to the 2000 Census, 13.2 percent of South Dakotans live below 100 percent of FPL compared to 12.4 percent for the nation. Over 33 percent (33.1%) of South Dakotans live under 200 percent of FPL compared to 29.6 percent for the nation. When looking at poverty levels for counties on Indian reservations in the state, these numbers are significantly higher with the four largest reservations in the state (Cheyenne River, Crow Creek, Pine Ridge, and Rosebud) representing the five poorest counties (Dewey, Ziebach, Buffalo, Shannon and Todd) in South Dakota. The percentage of the population below 100% FPL is: Dewey (Cheyenne River) -- 33.6%; Ziebach (Cheyenne River) -- 49.9%; Buffalo (Crow Creek) -- 56.9%; Shannon (Pine Ridge) -- 52.3%; and Todd (Rosebud) -- 48.3%. The percentage of the population below 200% FPL is: Dewey -- 66.0%; Ziebach -- 72.1%; Buffalo -- 79.9%; Shannon -- 77.7%; and Todd -- 73.4%.

According to the 2000 Census, 26.8% of the state's population are children (under the age of 18) while 6.8% are age 4 or younger. Over 41 percent (41.5%) of the state's female population is considered to be of childbearing age (age 15 through 44). South Dakota resident pregnancies totaled 11,846 in 2004 (21 of those were to women not in the 15-44 year age range).
/2007/ Just over 40 percent (40.4%) of the state's female population is considered to be of childbearing age (age 15 through 44). In 2005, there were 12,009 resident pregnancies (22 of those were to women not in the 15-44 year age range). //2007//
/2008/ 40% of the state's female population is considered to be of childbearing age (age 15 through 44). In 2006, there were 12,389 resident pregnancies (28 of those were to women not in the 15-44 year age range). //2008//
/2009/ 38.8% of the state's female population is considered to be of childbearing age (age 15 through 44). In 2007, there were 12,724 resident pregnancies (25 of those were to women not in the 15-44 year age range). //2009//
/2010/ 37.8% of the state's female population is considered to be of childbearing age (age 15 through 44). In 2008, there were 12,629 resident pregnancies (28 of those were to women not in the 15-44 year age range). //2010//
Pregnancies were estimated by totaling resident pregnancies producing at least one live birth, fetal deaths and abortions.

Access to primary care physicians is limited in the state. There were 712 active primary care physician licensed to practice in South Dakota as of February 2005 (family practice -- 336; internal medicine -- 207; pediatrics -- 78; OB/GYN -- 58; general practice -- 33). There is also 612 primary care midlevel providers -- 305 physician assistants, 291 nurse practitioners and 16 nurse midwives -- located in the state.
/2007/ As of May 2006, there were 802 active primary care physician licensed to practice in South Dakota (family practice -- 359; internal medicine -- 224; pediatrics -- 104; OB/GYN -- 79; general practice -- 36). There are also 694 primary care midlevel providers -- 350 physician assistants, 324 nurse practitioners and 20 nurse midwives -- located in the state. //2007//
/2008/ As of May 2007, there were 1,087 active primary care physician licensed to practice in South Dakota (family practice -- 496; internal medicine -- 306; pediatrics -- 136; OB/GYN -- 93;

general practice -- 56). There are also 711 primary care midlevel providers -- 361 physician assistants, 331 nurse practitioners and 19 nurse midwives -- located in the state. //2008//
/2009/ As of June 2008, there were 1,117 active primary care physician licensed to practice in South Dakota (family practice -- 519; internal medicine -- 301; pediatrics -- 122; OB/GYN -- 119; general practice -- 56). There are also 768 primary care midlevel providers -- 381 physician assistants, 361 nurse practitioners and 26 nurse midwives -- located in the state. //2009//
/2010/ As of May 2009, there were 1,093 active primary care physicians licensed to practice in South Dakota (family practice -- 522; internal medicine -- 305; pediatrics -- 116; OB/GYN -- 96; general practice -- 54). There are also 774 primary care midlevel providers -- 380 physician assistants, 371 nurse practitioners and 23 nurse midwives -- located in the state. //2010//
About two-thirds of the state is designated by the federal government as a Health Professional Shortage Area.

South Dakota has 50 general community hospitals, of which 36 are critical access hospitals (CAHs), as well as five IHS hospitals and three Veterans Administration hospitals. There are 28 federally qualified health centers (FQHCs) and 55 rural health clinics.
/2007/ There are 38 critical access hospitals in South Dakota. Only 30 of the 50 hospitals are currently licensed for obstetrical services. //2007//
/2008/ Only 27 of the 50 hospitals are currently licensed for obstetrical services. //2008//
/2009/ Twenty-nine of the 50 community hospitals are currently licensed for obstetrical services. //2009//

The economic status of individuals in the state, particularly in the Native American population, is a major barrier to access to services. Another factor to consider is transportation to access services. For some, this means traveling great distances (over 50 miles) to see a primary care provider and even further to see a specialist. On the Indian reservations, this problem is further complicated by the lack of a reliable transportation system.
/2008/ The DOH has initiated administrative rules revision which would allow for reimbursement for travel expenses incurred in traveling to specialty care for CSHCN. If approved, this reimbursement will be effective in Fall 2007. //2008//
/2009/ The administrative rules were effective October 17, 2007. //2009//

The Temporary Assistance for Needy Families (TANF) program is a temporary public assistance program administered by DSS and the Department of Labor. TANF is a needs-based program for families with children under the age of 18 (or under the age of 19 of the child is in high school) who need financial support due to: (1) death of a parent(s); (2) parent(s) absence from the home; or (3) physical/mental incapacity or unemployment of parent(s). The primary focus of the state TANF program is to help families help themselves by promoting family responsibility and accountability and encouraging self-sufficiency through work. For state FY 2004, there were 4,992 children receiving TANF benefits (195 less than FY03).
/2007/ In state FY 2005, there were 4,987 children receiving TANF benefits. //2007//
/2008/ In state FY 2006, there were 5,087 children receiving TANF benefits. //2008//
/2009/ In state FY 2007, there were 5,089 children receiving TANF benefits. //2009//
/2010/ In state FY 2008, there were 4,921 children receiving TANF benefits. //2010//

The state Children's Health Insurance Program (SCHIP) provides free health insurance to children under age 19 who meet certain eligibility guidelines. SCHIP covers doctor's appointments, hospital stays, dental/vision services, prescription drugs, mental health care, and other medical services. SCHIP provides health insurance coverage to uninsured children whose family income is up to 200% of FPL. Children who already have private health insurance may also be eligible for SCHIP to pay deductibles, co-payments and other medical services not covered by their private policy. At the end of FFY 2003 (ending 09-30-03), total enrollment in SCHIP was 62,733.
/2007/ At the end of FFY 2004 (ending 09-30-04), total children enrolled in SCHIP and Medicaid was 64,744. //2007//

/2008/ At the end of FFY 2006 (ending 09-30-06), total children enrolled was 67,552. //2008//
/2009/ At the end of FFY 2007 (ending 09-30-07), total children enrolled was 67,807 //2009//
/2010/ At the end of FFY 2008 (ending 09-30-08), total children enrolled was 69,200. //2010//

In 2004, the DOH released its DOH 2010 Initiative which provides a clear, concise blueprint for the future activities of the department. The Initiative outlines the goals and objectives for the department as well as key performance measures which will allow the DOH to monitor progress towards these goals. The Initiative also provides detailed action steps for each goal to help guide department activities. Specific individuals have been assigned the responsibility of leading the action steps needed to attain each of the 13 objectives.
/2007/ Progress on goals and objectives is reviewed quarterly. A copy of the revised DOH 2010 Initiative is provided as an attachment to this section. //2007//
/2008/ A copy of the current DOH 2010 Initiative is provided as an attachment to this section. //2008//
/2009/ A copy of the current DOH 2010 Initiative is provided as an attachment to this section. //2009//
/2010/ A copy of the current DOH 2010 Initiative is provided as an attachment to this section. //2010//

/2007/ Effective May 31, 2006, the use of all tobacco products, including smokeless tobacco, on properties under the direction and control of the Governor was prohibited. The Executive Order signed by the Governor was part of a joint effort with the state's three largest health systems to provide tobacco-free environments. The policy applies to employees, clients and visitors and includes vehicles, parking lots and walkways into state buildings throughout South Dakota. //2007//

/2007/ In 2004, South Dakota's infant mortality rate increased to 8.2 per 1,000 live births -- its highest level since 1999 and well above the U.S. rate of 6.6 infant deaths per 1,000 live births. As a result of this increase, the DOH established an ad hoc working group of health professionals to look at the causes of infant mortality in the state and recommend measures to reverse the trend. Members include practicing physicians representing the South Dakota State Medical Association (SDSMA) and representatives from the USD School of Medicine's Department of Pediatrics, IHS, and DOH.

There was a significant disparity by race with the infant mortality rate for Native Americans double that of whites, 13.3 per 1,000 live births compared to 6.9. The data points to tobacco use and lack of early prenatal care as major risk factors for low birth weight and pregnancy complications which can result in infant death. The infant mortality rate for babies born to mothers who used tobacco during pregnancy was much higher than for babies born to mothers who did not use tobacco during pregnancy, 12.8 deaths per 1,000 versus 7.2. There was also a strong link between early prenatal care and a lower infant mortality rate with the lowest infant mortality rate among mothers who started prenatal care in their first trimester, 6.9 per 1,000 live births. The highest rate, 59.4, was among mothers who had no prenatal care. //2007//
/2008/ The ad hoc working group reviewed the data and found that infant death is more common among mothers who received no prenatal care, smoked during pregnancy, were younger than 19 years of age, had not finished high school, were Native American, and lived in a "frontier" county. As a result of their findings, the working group identified six key activities to reduce the state's infant mortality rate to 6.0 infant deaths per 1,000 live births by 2010. These activities include: (1) developing a media campaign directed at helping women know they are pregnant and the importance of not smoking and early prenatal care; (2) establishing a physician training program with resources for health care providers on the importance of not smoking during pregnancy and early and regular prenatal care as well as medical markers to help them recognize and diagnose critically ill infants; (3) enhancing the relationship between Healthy Start and DOH programs; (4) working with the Trauma System Steering Committee to improve medical response for sick and injured infants in rural and frontier counties; (5) strengthening current services for teens and young mothers; and (6) publishing a report to increase awareness about the problem of infant

mortality. A copy of the full report of the working group can be found on the DOH website.

Biannual meetings will be held between MCH, IHS, AATCHB, and coordinators from the eight Healthy Start programs in South Dakota (Crow Creek, Lower Brule, Sisseton, Yankton, Pine Ridge, Rosebud, Flandreau, and Cheyenne River). The only tribe in South Dakota without a Healthy Start program is Standing Rock. The group will meet to discuss challenges, networking and how to help each other. One of the issues to be discussed is the lack of transportation systems on the reservations. The DOH has worked with the state Department of Transportation (DOT) to get transit maps of all the public transportation systems available across the state. This information has been shared with Healthy Start staff. DOT representatives will be invited to the October 2007 meeting to discuss public transportation system needs and options. / /2008// /2009/ Meetings were held in October 2007 and April 2008 with areas of discussion including: (1) awareness of the South Dakota Sales Tax on Food Refund Program which helps low-income families stretch their food dollars by providing refunds of sales tax payments on food to qualifying South Dakota residents; (2) causes of death among the state's Native American population; (3) tobacco use and tobacco prevention efforts for pregnant mothers and exposure to secondhand smoke by infants and children; (4) rural transit systems and how to access services; (5) metabolic screening; (6) update on the MCH block grant and data specific to the Native American population; and (7) family planning services and how to obtain pregnancy tests for clients so they are able to be aware of pregnancy earlier to begin prenatal care. //2009//
/2010/ Meetings were held in October 2008 and May 2009 with areas of discussion including: (1) Lifeline Linkup which is a telephone assistance program in Indian Country that allows households located on tribal lands to have access to affordable telephone services; (2) awareness of Family Planning locations in South Dakota and services provided; (3) CSHS program changes including income levels, coverage of services, and travel to medical visits; (4) EPSDT overview; (5) tobacco control and prevention efforts including use of QuitLine and affects of tobacco on the mother, unborn children, and other children; (6) child death in South Dakota including data on causes and rates of death among children; (7) FASD project including a discussion of the issues of drinking and pregnancy and the affect on the unborn child; and (8) discussion of upcoming changes to the WIC program food package that will be implemented by October 2009 and how it impacts the nutrition and diet of those who receive WIC services. //2010//

/2007/ In May 2006, the Yankton Sioux Tribe received federal funding from CDC for its Tribal PRAMS project. The Tribal PRAMS project will supplement existing vital statistics data as well as data collected through the department's Perinatal Health Risk Assessment survey and will provide an important source of information to help the state get a better understanding of maternal attitudes, behaviors and experiences for Native American women and their infants in South Dakota. Data can then be used by the state, IHS, tribal health programs, and the Northern Plains Tribal Epidemiology Center to target interventions and programs to help improve the health of Native American women and infants. The Tribal PRAMS project will also provide essential data to support progress towards achievement of many DOH Title V priority needs and outcome objectives. The MCH Project Director will contribute to the identification of maternal, infant and child health priorities to be addressed in the Tribal PRAMS project, assist in identifying potential uses of data and mechanisms for dissemination as well as incorporate data to improve programs and services for Native American communities throughout the state. //2007//

/2008/ A Trauma System Steering Committee is working to make recommendations for the development of a statewide trauma system for South Dakota. The trauma system would match the needs of injured patients to the capabilities of the facility and allow those individuals who are seriously injured to get to the appropriate level of care more quickly and receive needed treatment. Five subcommittees (injury prevention, pre-hospital, definitive care facilities/standards, information systems, and administration) are currently working to develop recommendations specific to their area for a coordinated statewide trauma system. //2008//
/2009/ During the 2008 South Dakota legislative session, SB 200 passed which authorizes the establishment of a comprehensive trauma system for the state. Over the next several months, the

DOH will be drafting administrative rules for the designation of hospitals, transfer protocols, and development and maintenance of a trauma registry. All hospitals in the state will need to be designated by January 1, 2012. The Office of Rural Health will be hiring a trauma coordinator to oversee the development of the trauma system. //2009//
/2010/ A trauma coordinator was hired in July 2008. A workgroup was established to draft the administrative rules necessary to implement the trauma system in the state. The rules were effective June 29, 2009 with the trauma system fully operational by January 1, 2012. //2010//

/2008/ During the 2007 South Dakota legislative session, there were several pieces of legislation which passed that impact the MCH population: (1) HB 1032 appropriated $40,000 to the DOH for the purpose of establishing a dental externship program in the state. The program will work with dental students entering their fourth year of training to place them in three-week rotations throughout the state. The purpose of the externship program is to help students gain real world practice experience by working with high need populations and foster the recruitment of additional dentists to the state; (2) HB 1061 authorizes the expenditure of funds to provide free HPV vaccine to young women aged 11 through 18 through a voluntary program; (3) HB 1162 makes it illegal for adults to give or buy cigarettes or other tobacco products for any person under the age of 18; (4) HB 1169 creates the Zaniya Project Task Force to develop a plan, complete action steps and timelines to provide health insurance to South Dakota residents who lack health insurance coverage. The task force will seek to create efficiencies in the purchase of health insurance products and for any new proposals it recommends, it shall prepare costs estimates and designate funding sources. The task force's report is due to the Governor and Legislature by September 30, 2007; and (5) SB 15 requires that beginning with the 2008 school year, any student entering a public or private postsecondary education institution in South Dakota to be immunized with two doses of immunization against measles, mumps and rubella. //2008//
/2009/ In addition to the trauma bill (SB200 noted above), there were two other pieces of legislation that passed during the 2008 South Dakota legislative session that impact the MCH population: (1)SB 29 appropriated $40,000 to the DOH to fund the second year of a dental externship program in South Dakota to work with fourth year dental students to place them in three-week rotations in the state for the purpose of helping students gain real world practice experience by working with high need populations and fostering the recruitment of additional dentists to the state; and (2) SB 34 allows the joint Board of Nursing (BON) and Board of Medical and Osteopathic Examiners (BMOE) to waive the collaborative agreement requirement for certified nurse midwives (CNMs) to attend out-of-hospital births in accordance with guidelines established and adopted by the joint boards. //2009//
/2010/ During the 2009 South Dakota legislative session, there were several pieces of legislation which passed that impact the MCH population: (1) SB 109 -- Permits children under the age of 19 to be enrolled in the South Dakota Risk Pool if they meet certain eligibility criteria (NOTE: the Risk Pool provides health care coverage for those who have recently lost insurance coverage and who cannot qualify for coverage anywhere else); (2) HB 1080 -- Bans non-face-to-face sales of cigarettes and tobacco products; (3) HB 1092 -- Provides for the regulation of the practice of genetic counselors in South Dakota through the Board of Medical and Osteopathic Examiners. No genetic testing may be provided unless specifically ordered by a licensed physician, nurse midwife, nurse practitioner, clinical nurse specialist, or physician assistant; (4) HB 1240 -- Prohibits smoking in any public place or place of employment. The only exceptions to the ban are hotel sleeping rooms and tobacco shops and cigar bars in operation as of January 1, 2009 (NOTE: Petitions were filed to refer the law to a vote which will delay enactment of the law until November 2010 pending approval of South Dakota voters); and (5) HCR 1006 -- Encourages South Dakota schools to place a sufficient number of automated external defibrillators (AEDs) in their facilities, at their athletic fields, and with their athletic staff, and to adopt a medical emergency response plan that includes AED use. //2010//

/2009/ The Zaniya (Lakota for "health and well-being") Task Force met monthly from April to September and issued its final report to the Governor and Legislature on September 30, 2007.

The 52-member task force was chaired by Lt. Governor Dennis Daugaard and represented by health care providers and facilities, insurers, employers, state government, trade associations, tribal health, and consumers. The task force was charged with developing a plan, action steps, and timelines to provide health insurance to South Dakota residents who lack coverage as well as seek efficiencies in the health care delivery system. To accomplish its work, the task force was divided into four workgroups. The Long Term Cost Containment Workgroup was charged with developing recommendations and strategies to help control health care costs including heath information technology, informed consumer choice, chronic disease management, lifelong wellness/disease prevention, and emphasis on treatment in the primary care setting. The Insurance Workgroup looked at developing recommendations and strategies to provide access to health insurance for the uninsured population. The Government Workgroup was charged with developing a list of recommendations and strategies for the role government entities would play, priority populations, the types of benefits to be offered, and how benefits would be provided. The fourth workgroup was the Indian Health Services Workgroup which looked at providing recommendations to improve access and health care services for Native Americans in the state through collaborative efforts between federal, state, and tribal governments as well as the private sector.

The final report presents recommendations to: (1) expand opportunities for purchasing more affordable, quality commercial health insurance for more South Dakota citizens; (2) extend health care coverage to more of South Dakota's low-income uninsured through premium subsidies for commercial insurance; (3) improve private and public health care purchasing in South Dakota by reducing costs and purchasing for value; and (4) improve health care coverage and health status of Native Americans living in South Dakota through targeted national, state, and tribal initiatives. The recommendations are designed to be comprehensive by not necessarily interdependent. Some recommendations were pursued immediately, some will require a longer time frame, and others will need approval from state and/or federal government or appropriate tribal authority. A copy of the final Zaniya Task Force Report can be found at http://zaniya.sd.gov.

In March 2008, Governor Rounds announced the appointment of Daryl "KC" Russell to serve as Director of the Governor's Indian Health Care Initiative. In this newly created position, Mr. Russell will be working with the tribes across South Dakota as well as state and federal agencies to identify solutions to health care issues for Native Americans. The creation of this new position came partly in response to the Zaniya Project Task Force's final report. Mr. Russell has served as Hospital Administrator for the Sisseton IHS facility and as Deputy Director of Aberdeen Area IHS. To assist in these efforts, the South Dakota Health Care Commission also has established a subcommittee to work with the Indian Health Care Initiative to identify the problems with the health care system for Native Americans and recommend possible solutions to the problems identified including federal and state policy and regulatory changes and opportunities to partner with the private sector.

During 2007, the DOH provided free HPV shots on a voluntary basis to all young women in the state between the ages of 11 and 18 to protect them against the virus that causes cervical cancer. The free vaccination program began on January 22, 2007 and ran through December 31, 2007. Nearly 40% of the eligible girls 11 to 18 years old received at least one dose of the HPV vaccine to help prevent cervical cancer and the DOH is completing the series for those who started in 2007. The DOH continues to provide the vaccine to all 12-year-old girls and to those 11 through 18 years who are eligible for the federal Vaccines for Children (VFC) program. //2009// ***/2010/ In CY08, 3,221 adolescent girls aged 11 to 18 years received the HPV vaccine. //2010//***

/2009/ In September 2007, Governor Rounds announced the state would offer free flu shots for South Dakota kids aged 6 months through 18 years, beginning with the 2007-2008 season. The DOH purchased the vaccine and supplied it to local clinics. Over 85,500 doses of flu vaccine were given to kids from 6 months through 18 years (about 41.5% of the eligible population) and compares to just 19,000 doses given to that age group during the 2006-2007 flu season. Vaccine

providers in the state have been notified that the initiative is ongoing and they will be able to order free flu vaccine for children through the Immunization Program for the 2008-2009 flu season. //2009//
//2010// In the second year of the initiative, more than 91,000 children were immunized against the flu during the 2008-09 flu season. //2010//

/2008/ In November 2006, South Dakota voters approved a $1 a pack increase in the cigarette tax which became effective on January 1, 2007. Of the revenues raised through the tax increase, $5 million was dedicated to the DOH's tobacco prevention and control program with $2.17 million going to cessation and statewide programming, $1.7 million going to community and school programming, and $1.13 million going to countermarketing, surveillance/evaluation and administration. In the area of cessation and statewide programming, the DOH will expand QuitLine services (i.e., free medications to QuitLine participants, additional choices for cessation medications, web-based cessation services/post-quit support), enhance the Tobacco Control Program website to provide more interactive features including enhanced links for employers, health care providers, communities, and others, and expand work with other state agencies to encourage program participants/clients to quit using tobacco. In the area of community and school programming, the DOH will look to implement a menu-style community coalition program to provide set dollar amounts for specific activities, provide grants to post-secondary institutions to implement tobacco-free policies and other tobacco prevention and cessation activities, and expand K-12 comprehensive tobacco prevention and cessation programming. Finally, in the area of countermarketing and surveillance/evaluation, the DOH will increase public education/messaging especially for populations with high use with some form of messaging delivered statewide each month, conduct independent program evaluation of countermarketing and local community and school projects to assess effectiveness in reaching intended populations and the influence of the message on the audience, and expand support to the Department of Human Services (DHS) "sales to minors" inspections. //2008//

/2009/ With the increased funding, the department has expanded QuitLine services to include free cessation products and offer a third opportunity for tobacco users to use the QuitLine. Since it began in January 2002, the QuitLine has assisted nearly 35,800 South Dakotans in their efforts to quit. Data for the CY 2006 indicates the QuitLine has demonstrated a 25% quit rate vs. 5% for people who try to quit on their own. Funds are also used to support tobacco prevention and cessation activities with participants in the Healthy Start program as well as expand public education and messaging efforts to included focused campaigns for pregnant women, young adults, and Native Americans. //2009//
/2010/ Since it began in January 2002, the QuitLine has assisted over 46,000 South Dakotans in their efforts to quit. Data for 2007 indicates the QuitLine has demonstrated a 31% quit rate vs. 5% for people who try to quit on their own. South Dakota provides 12 weeks of either Chantix or Zyban or 8 weeks of patches or gum for QuitLine participants regardless of income. The DOH has also expanded its public education/messaging efforts to include focused campaigns for pregnant women, young adults, and Native Americans, as well as secondhand smoke messaging. //2010//

/2008/ Through collaborative efforts, the MCH program has accomplished the following:
• Expanded the newborn metabolic screening to include Biotinidase deficiency, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders, fatty acid oxidation disorders, organic acid disorders and cystic fibrosis;
• Increased voluntary newborn hearing screening from 73.2% in 2001 to 96.8% in 2007;
• Decreased the death rate per 100,000 for 0-14 year olds by motor vehicle crashes from 10.3 in 2005 to 7.1 in 2006;
• Decreased the number of SIDS deaths from 1.1 in 2004 to 0.8 in 2006
• Increased the percent of 3rd grade children who received protective sealants on at least one permanent molar tooth from 49.4 in 2005 to 61.1 in 2006;
• Utilized the Ronald McDonald Dental Care Mobile to see over 4,000 children and provided a retail value of over $1.7 million of dental care;

• Established biannual meetings with Healthy Start directors from eight of the reservation areas to address prenatal care issues and big issues of transportation;
• Working with AATCHB on a CDC Tribal PRAMS survey; and
• Enacted several new state laws that will have a positive effect on the MCH population.

One of the biggest challenges for South Dakota and the MCH program continues to be the disparities of the state's Native American population:
• 48.5% of Native American women received prenatal care in the first trimester vs. 73.9% for White women;
• 5-year median infant mortality rate (infant deaths per 1,000 live births) for Native Americans is 2.5 times higher than Whites;
• 39.9% of Native American women smoked during pregnancy vs. 23.5% for Whites;
• 48.6% of Native American students were overweight/at risk of overweight vs. 31.6% for White students; and
• The birth rate for teens 18-19 years of age for Native Americans was 217.1 per 1,000 women 18-19 years of age vs. 47.1 for Whites. //2008//

/2009/ Through collaborative efforts, the MCH program has accomplished the following:
• Decreased the three-year average death rate per 100,000 for 0-14 year olds by motor vehicle crashes from 10.3 in 2005 to 5.1 in 2007;
• Decreased the number of SIDS death rate from 1.1 in 2004 to 0.8 in 2007;
• Increased the percent of 3rd grade children who received protective sealants on at least one permanent molar tooth from 46.4 in 2005 to 61.1 in 2007;
• Expanded the newborn metabolic screening panel to include cystic fibrosis as a mandated screen for all newborns (now screening 28 of ACMG core panel of conditions);
• Achieved an average turn around time of 5 days and 13 hours from birth to reporting of metabolic screening results;
• Contracted with Sanford Health System for long term follow-up to the metabolic program to assure all residing in South Dakota with a diagnosed metabolic disorder are getting appropriate care for their metabolic disorder;
• Utilized the Ronald McDonald Dental Care Mobile to see 6,077 children and provided a retail value of over $2.5 million of dental care;
• Continued biannual meetings with Healthy Start directors from eight of the reservation areas to address issues such as prenatal care, family planning, tobacco use, infant morality, and transportation;
• Working with AATCHB on a CDC Tribal PRAMS survey;
• Providing HIV testing to women when they come in for pregnancy testing;
• Increased collection of height and weight data from South Dakota schools (currently obtain data from over 242 school for 42,289 children); and
• Provided support for two additional staff for the Healthy Start programs on the Pine Ridge and Rosebud reservations. //2009//

/2010/ Through collaborative efforts, the MCH program has accomplished the following:
• Increased voluntary newborn hearing screening from 73.2% in 2001 to 98% in 2008;
• Achieved an average turn-around time of 5 days and 10 hours from birth to reporting of metabolic screening results which is two hours faster than the previous year;
• Serving 119 children (1992-present) through the Long-Term Follow Up for the metabolic program to assure children are receiving appropriate care for their metabolic disorder;
• Utilized the Dakota Smiles Mobile Dental Program to see 7,309 children and provided a retail value of over $3 million in dental care;
• Held biannual meetings with Healthy Start directors from eight of the reservation areas to address such issues as prenatal care, family planning, tobacco use, fetal alcohol syndrome, infant mortality, and transportation;
• Worked with the AATCHB on a CDC Tribal PRAMS survey;
• Provided 298 rapid HIV testing to adolescents 19 years of age and younger that were at high risk due to lifestyles; continued to provide HIV testing for women when they come in

for pregnancy tests;
• Provided support for two additional Healthy Start staff on the Pine Ridge and Rosebud reservations;
• Provided HPV vaccine to 3,221 adolescent girls aged 11 to 18 years;
• Provided influenza vaccines free-of-charge to 21,319 children aged 6 months to 18 years through Community Health Services/Public Health Alliance sites;
• Increased collection of height and weight data from South Dakota schools from 242 to 249 schools; obtained data on 37,028 students in these schools;
• Provided respite care to 1,432 children (985 families) with chronic medical conditions, developmental disabilities, and serious emotional disturbances;
• Sponsored outreach genetic clinics in two communities in South Dakota to decrease the travel miles and time for families to access these services; and
• Increased income eligibility up to 250% of the federal poverty level (FPL) with no family cost share for CSHCN. //2010//

An attachment is included in this section.

B. Agency Capacity

The DOH is charged with the protection of the public health by appropriate measures set forth and authorized by state law. South Dakota Codified Law (SDCL) 34-1-21 designates the DOH as the sole state agency to receive, administer and disburse federal Title V monies and authorizes the DOH to adopt rules to administer the Title V program relating to MCH and children with special health care needs (CSHCN) services. Administrative Rules of South Dakota (ARSD) 44:06 provides guidance on the delivery of services to CSHCN and outlines general operation of the program, eligibility requirements, providers, family financial participation, claims, and scope of benefits. SDCL 34-24-17 requires all infants born in South Dakota to be screened for the metabolic disorders of phenylketonuria (PKU), hypothyroidism, and galactosemia and ARSD 44:19 contains the rules regulating metabolic screening. These rules were updated in 2005 to expand the metabolic screening requirements to include biotinidase deficiency, congenital adrenal hyperplasia, hemoglobinopathies, amino acid disorders fatty acid oxidation disorders, and organic acid disorders. Screening for cystic fibrosis will be made available on an optional basis. /2008/ Effective May 7, 2007, the administrative rules for metabolic screening were updated to add cystic fibrosis as a mandated screen. //2008//

The Division of Health and Medical Services (HMS) is the health care service delivery arm of the DOH and administers MCH services. HMS consists of four offices and the State Epidemiologist.

OFFICE OF FAMILY HEALTH (OFH) -- OFH administers the MCH Block Grant for the DOH. OFH provides leadership and technical assistance to assure systems that promote the health and well-being of women of reproductive age, infants, children, and youth, including those with special health care needs and their families. OFH staff provide training and ongoing technical assistance to DOH field staff as well as private health care providers who deliver MCH services. Staff are responsible for the development of policies and procedures relevant to the delivery of MCH services for pregnant and postpartum women, infants, children, adolescents, and CSHCN. OFH works closely with field staff on data collection needed for federal and state reports as well as for program evaluation.

The Children's Special Health Services (CSHS) program directs care coordination services for children with chronic medical conditions. CSHS also coordinates diagnostic and consultative outreach and telemedicine pediatric specialty clinics and provides financial assistance for specified conditions and procedures on a cost share basis. Eligibility for the CSHS program was expended in 2004 to include individuals up to age 21.
/2008/ Effective June 1, 2007, CSHS no longer sponsors outreach specialty clinics. Specialists are still available at all outreach locations, but are there under their private practice. //2008//

/2009/ Effective August 1, 2008, the CSHS program will be providing additional financial assistance to families to assist with medical bills for coverable conditions. Under the new program, financial eligibility will be expanded so more families will be eligible for the program (up to 250% of FPL) and there will be no family cost share for eligible expenses with the program covering 100% of eligible covered expenses after other third party sources have been billed. The $20,000 annual cap on benefits will remain in place. In order to increase financial assistance to families, care coordination will no longer be the main focus of the program. While care coordination is an important function, families have indicated their top priority need from the CSHS program is financial assistance. To meet this need, CSHS will no longer provide care coordination through its four regional offices but will instead be available through the Central office and based on need as determined by ongoing risk assessment or family request. //2009// ***/2010/ All CSHS program changes were implemented August 1, 2008. //2010//***

The Perinatal program provides direction and technical assistance for primary and preventive care for women and infants including risk assessment and care coordination of pregnant women, perinatal education, prenatal/Bright Start home visits, developmental screenings, immunizations for infants/toddlers, sudden infant death syndrome (SIDS), and newborn metabolic and hearing screenings.

The Newborn Metabolic Screening program helps identify babies who may have a metabolic disorder and alerts the baby's physician to the need for further testing and special care.
/2007/ Beginning June 1, 2005, South Dakota expanded the number of mandated newborn disorders to be screened for to include 27 of the 29 American College of Medical Genetics (ACMG) report of core conditions. Of the ACMG report of secondary targets, South Dakota screens for 17 of the 25 deficiencies/ disorders. In addition, South Dakota screens for four deficiencies/disorders not listed on the ACMG report. Cystic fibrosis is available on an optional basis. //2007//
/2008/ Effective May 7, 2007, cystic fibrosis was added as a mandated screen. //2008//

The Newborn Hearing Screening program works with hospitals to encourage screening of newborns for hearing loss prior to hospital discharge or by one month of age. The program also works to ensure health care providers and parents are informed about the benefits of early hearing screening and that follow-up is provided to infants referred for further hearing evaluation. The Newborn Hearing Screening program utilizes the Electronic Vital Records and Screening System (EVRSS) to determine which infants have been screened/not screened as well as which infants need rescreening and/or follow-up.
/2008/ In May 2007, hearing screening equipment was purchased for the Birth to 3 program to assist in identifying delayed onset hearing loss in the Birth to 3 population served. //2008// ***/2010/ In 2008, began working with Early Head Start to use the hearing screeners previously located within Birth to 3 to monitor, gather screening results, and provide follow-up for children served by Early Head Start. //2010//***

The Women, Infants and Children (WIC) program promotes and maintains the health and well-being of nutritionally at-risk women, infants and children up to age five. Clients must meet income eligibility and be at nutritional risk. WIC provides nutrition education/counseling, breastfeeding support (i.e., information and breast pumps), healthy foods, referrals to health care providers and health/social services agencies, and immunizations (if needed).

The Family Planning program offers men and women of childbearing age reproductive health education, contraceptive counseling and methods, physical examinations, and sexually transmitted disease (STD) counseling, testing and treatment. Payment for family planning services is based on a sliding fee schedule according to family size and income.

The Child/Adolescent Health program coordinates a variety of activities designed to promote health, prevent disease and reduce morbidity and mortality among children and adolescents including abstinence, school health guidance, rape prevention, and intentional/unintentional injury

prevention.

OFFICE OF HEALTH PROMOTION (OHP) -- OHP coordinates a variety of programs designed to promote health and prevent disease. In addition to the programs below, the DOH recently hired a chronic disease epidemiologist to assist with the integration of chronic disease epidemiologic services throughout the DOH and provide support, technical assistance and guidance as needed. /2007/ The chronic disease epidemiologist provides epidemiological support for the chronic disease and health promotion programs as well as for MCH programs. //2007//

The All Women Count! (AWC) Breast and Cervical Cancer Control program coordinates statewide activities to promote early detection of breast and cervical cancer. Mammograms, Pap smears and related exams are available at no cost to eligible women at many physician offices, mammography units, family planning clinics, and other clinics throughout the state. AWC serves women (30-64 years of age for pap smears, 50-64 for mammograms) who are without insurance to pay for screening exams or who have insurance but cannot pay the deductible or co-payment. The Cancer Registry program ensures the coordination of cancer reporting in the state.

The AWC Chronic Disease Screening program is an expansion of the Breast and Cervical Cancer program and includes cardiovascular and diabetes screening for eligible women enrolled in AWC. The expanded program reimburses health care providers for screening, diagnosis, and patient education for diabetes and cardiovascular disease. Women not only are screened for cardiovascular disease and diabetes but also can be seen by a professional for four physical activity and nutrition sessions per year.

/2007/ The Nutrition and Physical Activity program provides resources, technical assistance and programs to a variety of target audiences such as parents and caregivers, schools/youth organizations, workplaces, communities, and health care providers to help prevent obesity and other chronic diseases. The Nutrition and Physical Activity program collaborates with many DOH programs to address poor nutrition and inadequate physical activity. With the help of a committed group of stakeholders, a "SD State Plan for Nutrition and Physical Activity to Prevent Obesity and Other Chronic Diseases" was released in 2006. The full plan can be found on the healthy.sd.gov website. //2007//

The Coordinated School Health program provides technical guidance and services to schools in the areas of nutrition, physical activity and tobacco use. The program is jointly administered with DOE.

The Diabetes Prevention and Control program designs, implements and evaluates public health prevention and control strategies to improve access to, and quality of, diabetes education for all persons with diabetes in South Dakota to reach those communities most impacted by the burden of diabetes, and delivers a broad range of public health activities to reduce death, disability and costs related to diabetes and its complications.
/2008/ In March 2007, the "South Dakota Diabetes State Plan 2007-2009" to reduce the impact of diabetes was released. The plan was developed by more than 60 individuals representing health care, advocacy groups, government agencies, tribal health, and quality improvement programs along with people who have diabetes and concerned family members. It details a wide range of activities for the next three years to reduce the impact of diabetes in South Dakota and improve the lives of those with the disease. The ultimate goal of the diabetes plan is to put in place a more effective system of early diagnosis, access to quality care, health promotion, and education so South Dakotans with this disease can live longer, healthier lives. A copy of the plan is available at http://diabetes.sd.gov. //2008//

The Oral Health program coordinates activities to increase awareness of the importance of oral health and preventive care, foster community and statewide partnerships to promote oral health and improve access to dental care, and promote the use of innovative and cost effective approaches to oral health promotion and disease prevention.

The Public Health Nutrition program is responsible for developing and managing nutrition activities for the DOH. The State Nutritionist serves as a spokesperson on issues that affect the nutritional health of the state and recommends appropriate nutrition interventions.

The Tobacco Prevention and Control program coordinates state efforts to prevent young people from starting to use tobacco products, help current tobacco uses quit, and reduce non-smokers' exposure to second-hand smoke.

OFFICE OF COMMUNITY HEALTH SERVICES/PUBLIC HEALTH ALLIANCE (OCHS/PHA) -- This office provides professional nursing and nutrition services and coordinates health-related services to individuals, families, and communities across the state. Services include education and referral, immunizations, developmental screenings, management of pregnant women, WIC, family planning, nutrition counseling/ education, and health screenings (i.e., blood pressure, blood sugar, vision, hearing, etc.). In most counties, these services are delivered at state DOH offices. In 12 /2007/ 11 //2007// Public Health Alliance sites, the office coordinates the delivery of services through contracts with local county governments and private health care providers.

OCHS also administers the Bright Start nurse home visiting program. This program is a community-based program in Sioux Falls and Rapid City that provides home visiting services to high-risk families during pregnancy, after delivery, and continuing until the child's third birthday. The program focuses on high-risk pregnant mothers and new parents with limited economic and/or social and health resources. Ideally, the visits begin during the pregnancy but can begin whenever the family is referred to the program. Interventions include: (1) prenatal, maternal, and infant/child health assessments and education; (2) infant/child developmental assessments; (3) parenting education; (4) health, safety, and nutrition education; and (5) linking families with other resources in the community to maximize their overall functioning. The Bright Start home visiting program began in April 2000. The following numbers of families have been served by the program: 246 in FY 2001, 323 in FY 2002, 331 in FY 2003, and 395 in FY 2004.
/2007/ 432 families were served in FY 2005. //2007//
/2008/ 455 families were served in FY 2006. //2008//
//2009// 487 families were served in FY 2007. Since 2001, the Children's Home Society of South Dakota in Sioux Falls has been a partner in the Bright Start Home Visiting Program by providing additional staff to the program at the Sioux Falls site. In November 2007, all of the Sioux Falls home visiting services and staff were transitioned from the DOH to the Children's Home Society and will continue to serve families in Sioux Falls. In January 2008, two additional staff were added in Rapid City to meet the growing caseload and demands. //2009//
/2010/ 476 families were served in FY 2008. In October 2008, one staff person was hired to begin providing Bright Start Home Visiting Service on the Pine Ridge Reservation. This allows the DOH to provide the program to pregnant women at Pine Ridge and allows for continuity of care for Native American women who are seen through the home visiting program in Rapid City and move between the Pine Ridge Reservation and Rapid City during their participation in the program. //2010//
The goal of the Bright Start program is to enhance the family's ability to care for itself and have a healthy baby. The program helps individual and families identify strengths and assists the family utilize and build on these strengths and skills.

OFFICE OF DISEASE PREVENTION (ODP) -- ODP provides vaccines for South Dakota's children to prevent such childhood diseases as measles, mumps, rubella, varicella, HiB, hepatitis B, and bacterial meningitis and provides recommendations and education on adult immunizations such as influenza, pneumonia and tetanus. Staff investigate sources of STD infections, provide treatment and apply preventive measures to those exposed. Field offices provide confidential counseling and testing for HIV/ AIDS as well as educational materials, training for the public, schools and health care providers, and assistance with health care costs for those with HIV disease. The office provides TB clinics and contracts with the private medical sector for evaluation, treatment and follow-up of TB cases. ODP also conducts disease outbreak

investigations in the state.

STATE EPIDEMIOLOGIST -- The State Epidemiologist integrates epidemiologic services throughout the DOH and provides support, technical assistance, and guidance as needed.

C. Organizational Structure

The DOH is an executive-level department with the Secretary of Health appointed by, and reporting to, the Governor. The mission of the DOH is to prevent disease and promote health, ensure access to necessary, high quality care at a reasonable cost, and efficiently manage public health resources. As was noted earlier, SDCL 34-1-21 designates the DOH as the sole state agency to receive, administer and distribute federal Title V monies as well as adopt rules to administer the Title V program relating to MCH and CSHCN.

The DOH is organized into three divisions -- Health and Medical Services, Administration and Health Systems Development and Regulation. As was mentioned above, HMS is the health care service delivery arm of the DOH. A detailed description of HMS offices and activities is provided under "Agency Capacity".

The Division of Administration provides centralized support to DOH programs including financial management, computer systems, communications, health planning, legislative coordination, grant writing, and research. The division also provides oversight of the state's correctional health care system. The Office of Data, Statistics and Vital Records (DSVR) provides technical assistance for the development, implementation and evaluation of data collection activities. DSVR has an FTE to oversee data collection and analysis activities for the MCH block grant. DSVR maintains the vital records system for the state including births, deaths, marriages, divorces, and fetal deaths and issues certified copies of such records. The State Public Health Laboratory provides testing, consultation and expert testimony in support of local, state and federal agencies and the general public.

The Division of Health Systems Development and Regulation administers regulatory programs related to health protection and health care facilities including the traditional public health areas of sanitation and safety, inspection and licensure of public facilities and Medicaid/Medicare survey and certification of health care facilities and providers. The Office of Rural Health (ORH) works to improve the delivery of health services to rural/medically underserved communities with an emphasis on access including recruitment of health professionals, technical assistance to health care facilities, development and use of telemedicine applications, and general information and referral.
/2009/ ORH will be hiring a trauma coordinator to oversee the development of the trauma system in South Dakota. //2009//
/2010/ A trauma coordinator was hired in July 2008. A workgroup was established to draft the administrative rules necessary to implement the trauma system in the state. The rules were effective June 29, 2009 with the trauma system fully operational by January 1, 2012. //2010//
The Office of Public Health Preparedness and Response directs the state's bioterrorism/public health emergency response efforts. A portion of the DOH's preparedness funding has been used to strengthen the public health infrastructure in South Dakota including improvements in communication and computer systems for MCH field staff.

A copy of applicable DOH organizational charts are provided as an attachment to this section.

An attachment is included in this section.

D. Other MCH Capacity

Preventive and primary care services to the MCH population are provided through OCHS. OCHS provides direction to state-employed nurses, nutrition educators, and dietitians for the provision of public health services in the state. Field staff providing primary preventive services for mothers, infants, and children include 6.8 FTE for mothers and infants and 7.4 FTE for children and adolescents.
/2007/ 8.0 FTE and 7.6 FTE, respectively. //2007//
/2008/ 8.45 FTE and 8.26 FTE, respectively. //2008//
/2009/8.57 FTE and 8.46 FTE, respectively. //2009//
/2010/ 6.89 FTE and 12.35 FTE, respectively. //2010//

Another 5.8 FTE provide family planning services in the state.
/2007/ 7.6 FTE //2007//
/2008/ 5.2 FTE //2008//
/2009/ 5.24 FTE //2009//
/2010/ 6.73 FTE //2010//

The service delivery system for CSHCN is a regional system with 17.75 FTE (including nursing, dietitian and social work) staff providing services at offices in Pierre, Sioux Falls, Aberdeen, and Rapid City /2007/ 18.1 FTE //2007// /2008/ 17.65 FTE //2008// /2009/16.0 FTE //2009//
/2010/1.0 FTE -- The reduction in FTE is due to the fact that care coordination is no longer provided through four regional offices but is instead available through the Central Office based on need and upon request. //2010//
Services are provided in a community-based manner that enables families to receive appropriate consultation and care planning as close to home as possible. Pediatric specialists, dieticians, registered nurses, and social workers function as a multi-disciplinary team with families to assist them in meeting the needs of CSHCN. The CSHCN service delivery system represents a unique public-private partnership between the DOH and numerous hospitals and physicians across the state.
/2009/ Effective August 1, 2008, the CSHS program will be providing additional financial assistance to families to assist with medical bills for coverable conditions. Under the new program financial eligibility will be expanded so more families will be eligible for the program(up to 250% of FPL) and there will be no family cost share for eligible expenses with the program covering 100% of eligible covered expenses after other third party sources have been billed. The $20,000 annual cap on benefits will remain in place. In order to increase financial assistance to families, care coordination will no longer be the main focus of the program. While care coordination is an important function, families have indicated their top priority need from the CSHS program is financial assistance. To meet this need, CSHS will no longer provide care coordination through its four regional offices but will instead be available through the Central Office and based on need as determined by ongoing risk assessment or family request.//2009//
/2010/All CSHS program changes were implemented August 1, 2008. //2010//

OFH and OHP central office program staff dedicated to providing program direction to specific MCH program areas include: 0.61 FTE for child and adolescent health; 1.74 FTE for perinatal health; 0.94 FTE for family planning services; and 1.11 FTE for CSHS.
/2007/ 1.2 FTE for child and adolescent health; 2.0 FTE for perinatal health; 1.22 FTE for family planning; and 1.3 FTE for CSHS //2007//
/2008/ 1.5 FTE for child and adolescent health; 1.8 FTE for perinatal health; 1.32 FTE for family planning; and 1.7 FTE for CSHS //2008//
/2009/ 1.66 FTE for child and adolescent health; 2.01 FTE for perinatal health; 1.48 FTE for family planning; and 2.02 FTE for CSHS //2009//
/2010/ 1.65 FTE for child and adolescent health; 2.37 FTE for perinatal health; 2.0 FTE for family planning; and 3.1 FTE for CSHS //2010//

Kayla Tinker, RN, is the administrator of OFH and serves as the MCH Program Administrator. Kayla has served in this capacity since December 1999. Prior to this position, Kayla served as the

Administrator of the Office of Public Health Alliance for three years and was a community health nurse supervisor for the DOH for over six year. Barb Hemmelman is the MCH Program Coordinator and serves as the CSHS Program Coordinator. Barb has been with the DOH since September 2004 and previously worked as the Director of the state's early intervention program within the DOE Office of Special Education. Everett Putnam serves as the MCH State Data Contact and has been with the DOH since December 1988. More detailed biographies for these positions are attached. Other MCH team members include the following:

- Linda Ahrendt /2009/ Vacant //2009// ***/2010/ Jane Hanson //2010//***, Physical Activity Coordinator
- Darlene Bergeleen, Administrator, Office of Community Health Services
- Kristin Biskeborn, State Nutritionist
- Julie Cholik /2007/ Jill Potter //2007// /2008/ Leslie Lowe //2008//, Child and Adolescent Health Coordinator
- Jacy Clarke, Chronic Disease Epidemiologist
- Terry Disburg, Newborn Hearing Coordinator
- Bev Duffel, Family Planning Director
- Josie Peterson, Office of Rural Health
- Julie Ellingson, Oral Health Coordinator
- Lucy Fossen, Newborn Metabolic Screening Coordinator
- Lon Kightlinger, State Epidemiologist
- Kathi Mueller /2009/ Anthony Nelson //2009//, Administrator, Office of Data, Statistics and Vital Records
- Nancy Shoup /2008/ Jenny Williams //2008//, Perinatal Nursing Consultant/CSHS Consultant
- Susan Sporrer, Division of Administration
- Colleen Winter /2009/ Linda Ahrendt //2009//, Administrator, Office of Health Promotion

-/2007/ June Snyder //2007// /2008/ Vacant //2008// /2009/ Derrick Haskins //2009//, Tobacco Control

-/2007/ Colleen Reinert, Coordinated School Health Coordinator //2007//

-/2007/ Stacey Skaff /2009/ Vacant //2009// ***/2010/ Christine Kayl//2010//***, Breastfeeding Coordinator //2007//

Through a contractual arrangement, South Dakota Parent Connection provides parent consultant and training services for CSHS program staff. Parent Connection identifies and recruits parents of CSHCN to provide mentoring and peer support to other families with CSHCN. They provide a family perspective to CSHS program staff regarding programs, policies and procedures, maintain a statewide database of support parents and groups, provide parent-to-parent training, and link parents throughout the state with trained supporting parents in a community-based manner. This relationship was formalized in 1999 and continues to expand and enhance family involvement in the CSHS program.
/2008/ While SD Parent Connection will continue to provide all activities identified above, there will no longer be a contractual agreement. //2008//

E. State Agency Coordination

South Dakota's public health system includes the DOH, community health centers (CHCs), IHS, and tribal health representatives. While many states use local health departments to deliver public health services, in South Dakota these services are delivered by the DOH and funded primarily with federal or state resources. There is only one local health department in the state located in Sioux Falls. However, it primarily focuses on environmental health issues.

Representatives from the DOH and the Community HealthCare Association of the Dakotas (CHAD) continually explore ways to increase collaboration and coordination of health services such as MCH, family planning, community health, and communicable disease control. In some areas, DOH staff are co-located with CHCs. Where feasible, local DOH staff meet regularly with

CHC staff to address identified needs and facilitate the development of a seamless system of care.

IHS delivers services to the Native American population on the state's nine reservations. There are IHS hospitals in Eagle Butte, Pine Ridge, Rapid City, Rosebud, and Sisseton. On many of the reservations, tribally-appointed community health representatives also provide services.

The DOH and DSS have an interagency agreement to establish and assure referral mechanisms between agencies. The intent of the agreement is to maximize utilization of services and assure that services provided under Title V and Title XIX are consistent with the needs of recipients and that the objectives and requirements of the two programs are met. The agreement establishes procedures for early identification and referral of individuals under age 21 in need of services such as early and periodic screening, diagnostic and treatment (EPSDT), family planning, case management, and WIC. Representatives from both agencies meet regularly to discuss various issues including care coordination of high-risk pregnant women, referral mechanisms, outreach for Medicaid, and SCHIP.

The DOH has a number of information and referral mechanisms to assist in the identification and enrollment of eligible children for Medicaid services such as WIC, CSHS, and OCHS/PHA. WIC facilitates referrals and links applicants with services so that families can access Medicaid as well as other health and social programs. In addition to the State program, there are three tribally-operated WIC programs on the Cheyenne River, Rosebud and Standing Rock Indian reservations. Coordination between the WIC and Medicaid program occurs as all Medicaid eligibility approvals of pregnant women are automatically reported to the WIC program on a weekly basis. OCHS/PHA staff serve as an information and referral source to inform families of Medicaid availability and facilitate enrollment in Medicaid by referral. /2007/ CSHS financial assistance process requires the family to also apply to Medicaid to ensure they are accessing all services that can be of assistance. //2007//

The South Dakota Family Planning Program provided services to 4,357 adolescents under the age of 19. Of these, 1,659 were between the ages of 15-17 and 4,150 were females.
/2007/ In CY05, SDFP provided services to 4,158 adolescents under the age of 19. Of these, 1,408 were between the ages of 15-17. //2007//
/2008/ In CY06, SDFP provided services to 3,926 adolescents under the age of 19. Of these, 1,457 were between the ages of 15-17. //2008//
/2009/ In CY07, SDFP provided services to 3,660 adolescents under the age of 19. Of these, 1,344 were between the ages of 15-17. //2009//
/2010/ In CY08, SDFP provided services to 3,043 adolescents under the age of 19. Of these, 1,298 were between the ages of 15-17. //2010//

Through Title X Special Funding for Regional Priorities funding, Downtown Women's Health Care (DWHC) in Sioux Falls provided community education on reproductive health topics to 6,422 adolescents in the Sioux Falls area.
/2007/ 4,141 in CY05 //2007//
/2008/ Special funding was not available in CY06 but presentations were still made to 3,550 adolescents. //2008//
/2009/ Presentations made to 4,155 adolescents //2009//
/2010/ Title X Special Funding is no longer available for this purpose. //2010//

SDFP also receives additional Title X funding to increase male involvement in family planning and reproductive health. Through a partnership with Boys and Girls Clubs of South Dakota, 111 young men aged 9-15 participated in the SMART Moves Primary Prevention Program between September 1, 2004 and December 31, 2004. The program was provided by clubs in Watertown, Aberdeen, Brookings, Fort Thompson, Wagner, and Eagle Butte.
/2007/ In CY05, 258 young men aged 9-15 participated in the SMART program which was provided in clubs in Watertown, Aberdeen, Brookings, Fort Thompson, Wagner, and Pierre.

//2007//
/2008/ In CY06, 288 boys participated in the SMART program which was provided in clubs in Watertown, Aberdeen, Brookings, Fort Thompson, Wagner, Pierre, and Sisseton. //2008//
/2009/ In CY07, 273 boys participated in the SMART program which was provided in clubs in Watertown, Aberdeen, Brookings, Fort Thompson, Wagner, Pierre, and Sisseton. //2009//
/2010/ Title X dollars for this program ended December 2007. //2010//

Youth and Family Services (YFS) in Rapid City receives Title X Family Planning funding directly from the Office of Population Affairs for a National Male Research and Demonstration Project. Through this grant, YFS provides the Wise Guys curriculum in Rapid City and surrounding areas.

The DOH receives funding through the Abstinence Education grant to fund local projects to provide abstinence only education. The majority of funded projects in South Dakota have utilized a broad-based youth development approach to teach abstinence. Youth development is a process which prepares young people to meet the challenges of adolescence through a coordinated, progressive series of activities and experiences which help them become socially, emotionally, physically, and cognitively knowledgeable. While abstinence education promotes the obvious goal of reducing adolescent pregnancy and STDs, it is also designed to equip youth with the skills necessary to avoid risky behaviors and enhance positive developmental factors important for growing into healthy, productive adults. In SFY05, five projects were funded -- Bethany Christian Services in Sioux Falls; National Abstinence Clearinghouse in Sioux Falls; Girls Scouts of Minne-Ia-Kota in Sioux Falls; Northern Hill Pregnancy Center in Spearfish; and Growing Up Together in Pierre.
/2007/ Current awards can be found on the DOH webpage at www.state.sd.us/doh/Abstinence/index.htm. //2007//

In 2003, the South Dakota Legislature passed a concurrent resolution supporting the creation of a South Dakota plan for suicide prevention. The resolution recognized that suicide is a significant problem in South Dakota and declared that prevention of suicide be made a state priority by strengthening the private and public entities charged with addressing the problem. The overarching goals of the suicide plan include: (1) implementation of effective, research-based suicide prevention programs to reach the public and at-risk populations (i.e., elderly, Native Americans, youth/young adults, and rural communities); (2) provision of guidelines to schools for the development of effective suicide prevention programs; (3) development of public information campaigns designed to increase public knowledge of suicide prevention; (4) work with postsecondary institutions to develop effective clinical and professional education on suicide; (5) assurance that schools have effective linkages with mental health and substance abuse services; and (6) implementation of effective, comprehensive support programs for survivors of suicide.

The DOH collaborates with DHS Divisions of Mental Health and Alcohol and Drug Abuse to address issues affecting children and adolescents and their families such as suicide, tobacco use, fetal alcohol syndrome (FAS), and HIV prevention. DOH staff provide assistance and representation on the Division of Alcohol and Drug Abuse Advisory Council for Safe and Drug-Free Schools application reviews and the Mental Health Planning and Coordination's Advisory Council subcommittee for children.
/2007/ MCH director also serves on Developmental Disabilities Council, FAS workgroup, and Highway Safety workgroup. //2007//
/2009/ MCH director also serves on Oral Health Advisory Board, Coordinated School Health Workgroup, Healthy South Dakota Workgroup, and State Diabetes Coalition. //2009//

DHS administers the state's Respite Care Program. The program is jointly funded with state general funds, MCH block grant funds, and some DSS federal grant funds. The Respite Care program offers services statewide. MCH block grant funds are expended to provide services for children on the program diagnosed with chronic medical conditions. CSHS program staff assist families with referral to the Respite Care Program. The program has an advisory group with representation from various state programs serving families who have children with special needs

including special education, child protection, developmental disabilities, mental health, and CSHCN. Parents are also represented on this group.

DHS and the Social Security Administration (SSA) have an expanded joint powers agreement with the DOH to assure that SSI child beneficiaries under age 18 are provided appropriate outreach, referral, disability determination, and rehabilitation services. Expansion of the agreement enables increased collaboration with DHS to promote coordination and delivery of services for children with severe emotional disturbances or developmental disabilities. The CSHS program manager is the DOH Title V liaison with DHS and SSA.

/2007/ DOH is involved in an interagency agreement with DOE, DHS, and DSS to ensure collaboration in the maintenance and implementation of a statewide, comprehensive, coordinated, multidisciplinary, and interagency service delivery system for children eligible under Part C of the Individuals with Disabilities Education Act (IDEA). This system is designed to ensure the availability and accessibility of early intervention services for all eligible infants and toddlers and their families. This agreement outlines the roles and responsibilities of the participating agencies related to the specific services required and provides guidance for their implementation. //2007//

South Dakota receives funding from CDC for a Coordinated School Health Program (CSHP) to support a collaborative relationship between DOE and DOH in efforts to help local schools implement and coordinate comprehensive school health programs directed towards the three CDC priority areas of nutrition, physical activity, and tobacco. DOH and DOE have a Memorandum of Agreement that outlines areas of responsibility and requirements to implement the program and have a developed a very effective relationship that allows for maximum use of financial and staffing resources. CSHP collaborates with the Department of Game, Fish and Parks (GFP) to offer the "Fantastic Field Trips" to teachers at no cost. Each teacher receives a packet of information including core content-based lessons and physical activity options while visiting the park. The "South Dakota Healthy Schools Awards" are given in three categories (elementary, high school and district-wide) to schools the exemplify health programs and policies.

/2008/ South Dakota Schools Walk is a partnership between the DOH, DOE, and schools to encourage students to be more active. Schools Walk is open to children of all ages but students in grades K-6 are eligible to receive incentives for their walking. In October 2006, Governor Rounds led more than 400 elementary students from Spearfish on a walk around their campus to kick off International Walk to School Week. The DOH continues to offer mini-grants to schools to support activities to improve nutrition and increase physical activity. These grants have allowed schools to use creative methods to address obesity in youth. //2008//
/2009/ In 2007-08, incentives were awarded to over 5,000 K-2 students and approximately 5,000 3-6 grade students who participated in the Schools Walk program. In addition, 750 staff were also involved. //2009//
/2010/ In 2008-09, South Dakota Schools Walk involved 6,500 K-6 grade students and 310 staff. New this year was the Schools Walk After School Program which involved 2,962 K-6 grade students and 298 staff. //2010//

Delta Dental Plan of South Dakota and Ronald McDonald House Charities have created a Ronald McDonald Care Mobile program in South Dakota. In September 2004, Delta Dental was granted a Ronald McDonald Care Mobile van with two fully equipped dental operatories which travels statewide to increase access to dental care in underserved areas of South Dakota. As a key partner with Delta Dental, the DOH has committed to staffing and coordinating services, as well as allocating resources to aid in providing oral health education, immunizations, and assistance in maintaining a referral system for patients of the Care Mobile. Providing primary dental care to children in these remote areas will emphasize the importance of preventive measures such as early intervention and continuing oral health education.

Since September 2004, the Ronald McDonald Care Mobile has visited 16 communities across the

state with 1,652 children receiving preventive services on the Care Mobile. Of those, 862 were Medicaid/ SCHIP enrolled children.
/2007/ Since September 2004, the Care Mobile has visited 28 communities across the state with 2,866 children receiving preventive care. Of those, 1,450 were Medicaid/SCHIP enrolled. To date, 15,582 diagnostic and preventive procedures and 4,997 restorative procedures have been performed. The retail dollar value of care provided was $1,125,714. //2007//
/2008/ Since September 2004, the Care Mobile has visited 31 communities across the state with 4,324 children receiving preventive care. Of those, 50% were Medicaid/SCHIP enrolled. Delta Dental reports that 55% of the children receiving services on the Care Mobile also required restorative dental care. To date, 24,416 diagnostic and preventive procedures have been performed and 7,881 restorative procedures have been performed. The retail dollar value of care provided was $1,761,299. In January 2006, the Care Mobile began tracking patient ethnicity, household income and other dental and medical statistics from their patients. Of the 1,883 children seen in 2006 and so far in 2007, 64% come from households where the income is less than $20,000. The Care Mobile was the first dental visit for 25% of children seen and 10% of the children being seen for the first time were over the age of 13. Thirteen percent of the children seen indicated they were in pain. //2008//
/2009/ As of January 31, 2008, the Care Mobile has visited 40 communities across the state with 6,077 children seen. Of those, 50 percent were Medicaid/SCHIP enrolled and 43 percent had no dental insurance. Sixty-three percent of the children seen come from households with an income of less than $20,000. The Care Mobile was the first dental visit for 25 percent of the children seen and 8 percent of the children being seen for the first time were over the age of 13. Thirteen percent of the children seen indicated they were in pain. To date, 35,079 diagnostic and preventive procedures and 10,744 restorative procedures have been completed. The retail dollar value of care provided is over $2.5 million. //2009//
/2010/ As of May 31, 2009, the Dakota Smiles Program has visited 53 communities across the state with 8,549 children seen. Of those, 49 percent were Medicaid/SCHIP enrolled and 44 percent had no dental insurance. Sixty-one percent of the children seen came from households with an income of less than $20,000. The Dakota Smiles Program was the first dental visit for 24 percent of the children seen and 8 percent of the children being seen for the first time were over the age of 13. Eleven percent of the children seen indicated they were in pain. To date, 50,558 diagnostic and preventive procedures and 15,750 restorative procedures have been completed. The retail dollar value of care provided is nearly $3.7 million. //2010//

The number of children needing multiple appointments and the extent of the disease in the population served has resulted in the need to revisit initial Care Mobile goals by decreasing the total number of children seen in a year.
/2009/ The current Care Mobile is booked through 2010. In order to meet the great need for dental care, Delta Dental is purchasing a second mobile unit which is scheduled to begin operation in late fall 2008. //2009//
/2010/ The Smile Mobile was added to meet the demand for dental care. Both the Ronald McDonald Care Mobile and Smile Mobile operate under the program name "Dakota Smiles Mobile Dental Program". //2010//
Overall, the Dakota Smiles Mobile Dental Program is meeting its program goals of improving the oral health of some of South Dakota's most underserved children.

The DOH has a long-standing collaborative relationship with the Center for Disabilities within the USD School of Medicine's Department of Pediatrics. The South Dakota Leadership Education Excellence in Caring for Children with Neurodevelopmental and Related Disorders (LEND) is a program of the Center for Disabilities that works to improve the health status of infants, children, and adolescents with neurodevelopmental and related disabilities. The LEND program provides one year of specialized training focusing on the interdisciplinary training of professionals for leadership roles in the provision of health and related services to infants, children and adolescents with neurodevelopmental and related disabilities and their families. The program augments graduate studies in the disciplines of audiology, health administration, medicine,

nursing, nutrition, speech-language pathology, occupational/physical therapy, pediatric dentistry, psychology, and public health social work. Both the Title V MCH director and CSHS director serve on the LEND advisory group. In addition to LEND, MCH and the Centers for Disabilities collaborate on a number of training and other interagency projects. /2008/ The CSHS director is a member of the Consumer Advisory Committee for the Center for Disabilities. //2008//

/2007/ "SD Connect" is a project of the South Dakota Health Care Commission. A Commission subcommittee was charged with reviewing programs that offer services to individuals not meeting eligibility requirements for income-based programs. The subcommittee focused its efforts on development of a website that will provide a comprehensive list of services available to residents to assist them in meeting health, social services and mental health care-related needs. While the initial focus of the website will be state agency services and programs within the DOH, DSS and DHS, the goal is to eventually expand it to include private sector resources as well. It is anticipated the "SD Connect" website will be operational by September 1, 2006. The MCH Program Director has coordinated the project on behalf of the Health Care Commission subcommittee. //2007//
/2008/ SD Connect (www.sdconnect.sd.gov) was launched May 21, 2007 to serve as an information gateway for South Dakota citizens to quickly find services and resources without knowing the name of the program or the department where the program is housed. Employees with DOH, DHS and DSS were required to complete an online training for the website so they are better able to serve individuals calling in for information. The training makes employees aware of the site, know its functionalities, and use it as a resource tool. The goal of the website is to minimize the amount of calls that are transferred and go back and forth between the three agencies. This site will enable staff the ability to find out about the different services offered and who to direct the call to at the click of a mouse. Accessing information through SD Connect can be done in multiple ways: (1) search all of SD Connect at once; (2) search DOH, DSS and DHS individually; (3) search all of state government; or (4) search specific information through key words and frequently asked questions. //2008//

/2009/ In April 2008, DSS was awarded over $7.6 million in grant funds from the Centers for Medicare and Medicaid Services (CMS) to provide health care services in non-emergency room settings. South Dakota was one of 20 states to receive federal funding, receiving the largest award of all states and having the most projects funded. Projects supported by the grant are located in Martin, Mission, Pine Ridge, Wagner, Sioux Falls, and other South Dakota locations. The focus in on providing access to non-emergency care to improve health outcomes and decrease the use of costly hospital emergency rooms. Grant funds will support health care staff recruitment, extended clinic hours, enhanced technology to link professionals to isolated communities, health education, chronic disease management clinics, and school-based health care services. The project will help South Dakota develop innovative ways to provided needed health care to people in South Dakota, especially in reservation communities. The DOH was actively involved in writing the grant and will provide assistance as the grant is implemented. //2009//
/2010/ The DOH continues to provide technical assistance on the CMS grant. Through the grant, a mobile medical clinic is being developed for the Pine Ridge Reservation. The mobile clinic (which is scheduled for delivery in August 2009) will provide a medical home for pregnant women and children up to age 21 on the Pine Ridge Reservation. Two staff members have been hired with the remaining three position yet to be filed. School, tribal, IHS, and other health officials are eager for the clinics to begin as it will be an innovative way to provide needed health care to children and young women of the Reservation. In conjunction with Oglala Sioux Tribal Health and IHS, radio shows dealing with health needs, resources, and preventive activities have begun on the local radio station. //2010//

/2009/ The DOH is partnering with Brulé to encourage people to get screened for cancer. Brulé (whose members are all South Dakota natives) has become one of the top-selling Native American recording artists with more than a million CDs sold worldwide. While the focus of the first message is cancer screening, the DOH hopes to expand the collaboration to include other

universal health messages in the future. The multi-cultural theme is especially applicable to the state's Native American populations. //2009//

F. Health Systems Capacity Indicators

Introduction

As was noted earlier, the MCH program works collaboratively with partners throughout the year on programs and strategies to improve the health of women, infants, children, adolescents, and CSHCN. The MCH program utilizes State Systems Development Initiative (SSDI) funds to access community hospital discharge data from the South Dakota Association of Healthcare Organizations (SDAHO) to address MCH Performance Measures. In addition, SSDI funds are used to conduct the Perinatal Health Risk Assessment Survey of new mothers to obtain data on behaviors and care/education received prior to, during and post pregnancy. Data collected via the survey are used to address MCH performance measures. SSDI funds are instrumental in maintaining the link between the state's EVRSS and the Newborn Metabolic and Hearing Screening programs.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	25.9	17.0	19.7	18.8	18.4
Numerator	134	89	103	103	104
Denominator	51720	52218	52218	54828	56450
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008

2007 South Dakota Association of Healthcare Organizations hospital discharge data. Rate based on 2007 South Dakota population estimate and 2007 community hospital discharges only.

Notes - 2007

2006 South Dakota Association of Health Care Organizations hospital discharge data. Rate based on 2006 South Dakota population estimate and 2007 community hospital discharges only.

Notes - 2006

2006 South Dakota Association of Health Care Organizations hospital discharge data. Rate based on 2005 South Dakota population estimate and 2006 community hospital discharges only.

Narrative:

The DOH uses SSDI funds to maintain the established access to hospital discharge data collected by SDAHO. SDAHO supplies de-identified file of the hospital discharge data to the DOH. In the past, SDAHO only had information for hospitals that were members of the Association which left gaps in the data set. However, in the 2005 the South Dakota Legislature passed a law (SDCL 34-12E-11) requiring hospitals to report charge information for certain diagnostic-related groups. While the original intent of the legislation was to provide charge reporting by hospitals, it has also benefited the DOH by improving the completeness of the discharge data set from community hospitals. The DOH will continue to work with the SDAHO to

enhance the reliability and accuracy of this data source. SDAHO transfers data to the DOH in May of each year and the data is used for a variety of purposes, including use for MCH block grant reporting. While data is received from 100 percent of community and specialty hospitals in South Dakota, IHS and Veterans Administration hospitals are not required to report data. ARSD 44:66 governs the process for hospitals to submit discharge data. These rules are in the process of being revised to change the form used to gather data from the UB-92 form to the new standard of CMS Uniform Bill-04. Those rule changes will be effective later this summer.
/2009/ The new administrative rules were effective September 10, 2007. //2009//
/2010/ The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age shows a slight downward trend. While the rates fluctuate over the years, only the 2004 rate is significantly different from the 2005 rate. The data for this measure comes from SDAHO hospital discharge data which does not include IHS data. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	86.1	86.3	87.7	84.7	82.7
Numerator	4952	5182	5334	5504	5225
Denominator	5753	6008	6079	6501	6319
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Notes - 2006
2006 South Dakota Department of Social Services Medicaid data.

Narrative:
Data is received from the Medicaid office within DSS. Community Health Nursing (CHN) offices providing MCH services collaborate with the WIC and Immunization programs to identify children in need of referral for an initial or periodic screen. Ages and Stages developmental questionnaires are provided to parents periodically to assess their child's developmental stages.

Annual indicator went from 86.3 to 87.7 which reflects more Medicaid enrollees under the age of one year are receiving appropriate periodic screening.
/2009/ The percent Medicaid enrollees whose age is less than one year during the reporting period who received at least one initial periodic screening shows an almost flat trend. While the rates fluctuate over the years, only 2006 and 2007 are significantly different from the other years. //2009//
/2010/ The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one periodic screen shows an almost flat trend. While the rates fluctuate over the years, 2006 and 2007 are significantly different and 2008 is

significantly different from the other years. The data for this measure comes from the DSS Medicaid program. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	100.0	100.0	91.1	84.6	82.9
Numerator	92	135	123	104	92
Denominator	92	135	135	123	111
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Notes - 2006
2006 South Dakota Department of Social Services Medicaid data.

Narrative:
Data is received from the Medicaid office within DSS. CHN offices providing MCH services collaborate with the WIC and Immunization programs to identify children in need of referral for an initial or periodic screen. Ages and Stages developmental questionnaires are provided to parents periodically to assess their child's developmental stages.

Annual indicator went from 100 to 91.1 which reflects a decrease in SCHIP enrollees under the age of one year receiving appropriate periodic screening. Since these enrollees have private insurance as the primary payer, it is possible that they are receiving appropriate periodic screening that is being paid for by the primary payer with SCHIP serving as the secondary payer. /2009/ The percent SCHIP enrollees whose age is less than one year during the reporting year who received at least one periodic screen shows a downward trend. //2009//
/2010/ The percent SCHIP enrollees whose age is less than one year during the reporting year who received at least one periodic screen shows a downward trend. The data for this measure comes from the DSS Medicaid program. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	77.5	77.9	72.1	73.5	74.0

Numerator	8616	8798	8434	8849	8749
Denominator	11124	11288	11695	12039	11824
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data

Notes - 2006
2006 South Dakota birth certificate data.

Narrative:
The DOH Baby Care, Family Planning and WIC programs strongly encourage pregnant women to seek early and regular prenatal care. Surveys of mothers conducted by the DOH have indicated the main reasons they didn't receive prenatal care in the first trimester is they were waiting to qualify for Medicaid or they didn't know they were pregnant. A DOH survey of health care providers indicated that providers felt women did not understand the importance of prenatal care.

The annual indicator went from 77.9 to 72.1 which reflects a decrease in prenatal visits. The DOH recently implemented the "I Didn't Know" media campaign aimed at increasing awareness of the importance of early prenatal care and recognizing the signs of pregnancy.
/2009/ Data for this Health Systems Capacity Measure shows a slight downward trend. While the rates fluctuate over the years, only 2006 and 2007 are significantly different from the other years. Caution should be used in interpreting this data due to a change in the birth certificate structure and the way these data are collected. The initiation of prenatal care for the 2006 and later data are determined using date last normal menses began and date of first prenatal care visit. Data prior to 2006 used the month prenatal care began provided on the birth certificate. //2009//
/2010/ The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index shows a slight downward trend. While the rates fluctuate over the years, 2004 and 2005 are significantly different from the other years and the 2006 rate is also significantly different from 2008. Caution should be used in interpreting this data due to a change in the birth certificate structure and the way these data are collected. The initiation of prenatal care for the 2006 and later data are determined using date last normal menses began and date of first prenatal care visit. Data prior to 2006 used the month prenatal care began provided on the birth certificate. //2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	80.0	80.0	79.5	81.4	82.3
Numerator	77151	78906	79423	81319	83033
Denominator	96439	98633	99903	99903	100902

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Notes - 2006
2006 South Dakota Department of Social Services Medicaid data.

Narrative:
Data is received from DSS Medicaid Office. DOH collaborates with DSS to assure Medicaid/ SCHIP information and application forms are available at all DOH field offices for clients who may be eligible. There is also a link to the Medicaid website from the DOH website. All potentially eligible clients who received WIC, Baby Care, or CSHS services are asked to apply for Medicaid. Staff assist in completing the process as needed.

Performance indicator went from 80.0 to 79.5. However, this decrease may be a result of the child not requiring any services. The DOH will continue to monitor to determine of there are adjustments to the system that need to be made to assure that all potentially eligible clients receive needed services.
/2009/ The percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program shows a slight upward trend. While the rates fluctuate over the years, only 2007 is significantly different from the other years. //2009//
/2010/ The percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program shows a slight upward trend. While the rates fluctuate over the years, only the 2007 and 2008 are significantly different from the other years, while the 2007 rate is significantly different from all the other years. The data for this measure comes from the DSS Medicaid program. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	36.5	35.9	39.7	38.8	45.2
Numerator	7179	7268	8211	8093	9733
Denominator	19651	20225	20661	20880	21526
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Notes - 2006
2006 South Dakota Department of Social Services Medicaid data.

Narrative:
DOH collaborates with partners in the Oral Health Coalition to assure that families who are eligible for Medicaid/SCHIP are aware they are eligible for dental services. The DOH has provided training to WIC and OCHS staff on oral health including discussions regarding Medicaid eligibility and access to care for Medicaid/SCHIP clients. Efforts continue to collaborate with CSHP to inform school nurses of oral health programs and initiatives through newsletters, School Nurse Notes, and participation in annual conferences.

The percentage of Medicaid-eligible children receiving dental care has increased gradually from 2000-2006. In 2000, 22.3% of Medicaid-eligible children received dental services, while in 2006, 30.2% received services. Since 2000, the number of dentists serving the Medicaid population in South Dakota has grown from 268 in 2000 to 310 in 2006.
/2010/ The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year shows an upward trend. While the percentages fluctuate between the years, 2008 is significantly different from the other years. In 2006, Delta Dental helped two large Head Start programs -- Aberdeen Area Head Starts and Inter Lakes Community Head Starts -- with their mandatory dental screenings and fluoride varnish applications and helped them establish relationships with local providers to do the screenings and Head Start nurses are now doing the fluoride varnishes. Most of the dentists in the communities are now doing the screening for free or the funding is coming from the Head Start budget. The 2008 increase may be attributed to at least one of the following: (1) addition of a second Mobile Dental Care Mobile; (2) SDDA emphasis on fluoride treatments for kids; (3) large spike in January 2008 for a couple of dentists doing fluoride varnishes; (4) increase in patients seen at CHCs; (5) significant Medicaid reimbursement rate increases for the services received; and (6) new dentists beginning practice in the past year who accept Medicaid patients. If a rate increase resulted in greater access, then it would affect the number of kids who received a service. Delta Dental shows the total children patients grew by over 15% from 2007 to 2008. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	40.3	46.3	34.7	36.5	29.1
Numerator	609	757	605	677	557
Denominator	1512	1636	1746	1857	1916
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota Department of Social Services Medicaid data

Notes - 2007
2007 South Dakota Department of Social Services Medicaid data

Notes - 2006
2006 South Dakota Department of Social Services Medicaid data.

Narrative:
The DOH collaborates with SSA and DHS programs serving children with chronic medical conditions, severe emotional disorders or developmental disabilities and promotes outreach and access to rehabilitative services, mental health services, medical care, and service coordination. An ongoing joint powers agreement between DOH, DHS, and SSA assures that SSI child beneficiaries and potential beneficiaries under the age of 18 are provided appropriate outreach, referral, disability determination, and rehabilitation services.

Annual indicator went from 46.3 to 34.7 which reflects a smaller percentage of SSI eligible clients receiving services from the state CSHS program. There is no direct linkage between SSI and the state MCH system. Data collected by the CSHS program on SSI eligibility is client reported and therefore more clients could be dually served than are reflected.
/2010/ The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the CSHCN program shows a downward trend. While the rates fluctuate over the years, caution should be used in interpreting this data due to a change in the data source for this indicator. The denominator data used in this measure for 2007 and later has been obtained from SSA. Due to the change in the CSHS program and discontinuing sponsoring clinics, the CSHS program sees fewer SSI beneficiaries. //2010//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	6.6	6.4	6.5

Narrative:
Data is received from DSVR and Medicaid. Through the DOH Baby Care program, pregnant women are provided information on warning signs of preterm labor. Staff have been advised by several women that they have not received this information from their health care provider, but through the education provided by Baby Care, and they were able to identify signs and symptoms or preterm labor and seek appropriate medical attention.

The percent of low birth weight babies increased across all populations. The small numbers tend to produce rates with more variability than larger numbers due to chance variations.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	payment source from birth certificate	12	6.4	8.2

Narrative:
Data is received from DSVR and Medicaid. The infant mortality rate within the state has increased resulting in concerns as to the potential causes for the increase. The DOH convened a workgroup to look at issues surrounding infant mortality within the state. The workgroup reviewed data and found infant death is more common among mothers who received no prenatal care, smoked during pregnancy, were younger than 19 years of age, had not finished high school, were American Indian, and lived in a "frontier" county. As a result of the findings, the workgroup identified six key activities to reduce the state's infant mortality rate to 6.0 infant deaths per 1,000 live births by 2010.

Although the infant mortality rates appear to be fluctuating and the trends tend to indicate direction for the years 2002-2006, the 95 percent confidence intervals reveal that that we should not consider any of the yearly changes significantly difference from anther because of the natural variations one should expect in the events. The five year average number of infants dying annually is less than 100, averaging 80 events annually. The neonatal mortality numbers averages 45 annually over the same five years while the postneonatal mortality averages 35 events per year. The small numbers tend to produce rates with more variability than larger numbers due to chance variations. Even with the fluctuating rates the objective are generally within the rate confidence intervals.
/2010/ The Medicaid population infant deaths per 1,000 live births shows an upward trend. While the percents fluctuate over the years, none of the years are statistically different. The numbers used to calculate these rates are relatively small and tend to yield wider confidence intervals than larger numbers would produce. The non-Medicaid population infant deaths per 1,000 live births shows a downward trend, however none of the years are statistically different. When comparing the percents between the Medicaid and non-Medicaid populations for each year, only the 2008 percents are significantly difference. The total population infant deaths per 1,000 live births shows an almost flat trend. While the percents fluctuate slightly over the years, none of the years are significantly different. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to	2008	payment source	56	73.8	67.7

pregnant women receiving prenatal care beginning in the first trimester		from birth certificate			

Narrative:
The DOH Baby Care, Family Planning, and WIC programs strongly encourage pregnant women to seek early and regular prenatal care. A survey of mothers conducted by the DOH indicate the main reasons they did not receive prenatal care in the first trimester was they were waiting to qualify for Medicaid or they didn't know they were pregnant. A DOH survey of health care providers indicated that providers felt women did not understand the importance of prenatal care.

The percent of pregnant women receiving prenatal care in the first trimester decreased across all populations. The DOH recently implemented the "I Didn't Know" media campaign aimed at increasing awareness of the importance of early prenatal care and recognizing the signs of pregnancy.
/2010/ Both the Medicaid and non-Medicaid population percent of infants born to pregnant women receiving prenatal care beginning in the first trimester shows a downward trend. While the percents fluctuate over the years, only the 2004 and 2005 percents are significantly different from the other years. When comparing the percents between the Medicaid and non-Medicaid populations for each year, only the 2008 percents are significantly different. The total population percent of infants born to pregnant women receiving prenatal care beginning in the first trimester shows an almost flat trend. While the percents fluctuate over the years, only the 2004 and 2005 percents are significantly different from the other years. Caution should be used in interpreting this data due to a change in the birth certificate structure and the way these data are collected. The initiation of prenatal care for the 2006 and later data are determined using date last normal menses began and date of first prenatal care visit. Data prior to 2006 used the month prenatal care began provided on the birth certificate. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	70	76	74

Narrative:
Data regarding entry into prenatal care is retrieved from the birth certificate. Information regarding barriers to access is obtained through questions on the Perinatal Health Risk Assessment Survey. All women of childbearing age accessing services within CHN offices are strongly encouraged to obtain early and regular prenatal care. Through case management services for pregnant women, appointments with prenatal care providers are facilitated.

The percent of pregnant women receiving adequate prenatal care has decreased across all population. The DOH recently implemented the "I Didn't Know" media campaign aimed at increasing awareness of the importance of early prenatal care and recognizing the signs of pregnancy.

/2010/ The Medicaid population percent of pregnant women with adequate prenatal care (observed to expected prenatal visits greater or equal to 80% [Kotelchuck Index]), shows a downward trend. While the percents fluctuate over the years, only the 2004 and 2005 percents are significantly different from the other years. The non-Medicaid population percent of pregnant women with adequate prenatal care (observed to expected prenatal visits greater or equal to 80% [Kotelchuck Index]), shows an almost flat trend. While the percents fluctuate over the years, only the 2004 percent are significantly different from the other years. When comparing the percents between the Medicaid and non-Medicaid population for each of the given years, there are no significant differences. The total population percent of pregnant women with adequate prenatal care (observed to expected prenatal visits greater or equal to 80% [Kotelchuck Index]), shows a downward trend. While the percents fluctuate over the years, none of the years are significantly different. Caution should be used in interpreting this data due to a change in the birth certificate structure and the way these data are collected. The initiation of prenatal care for the 2006 and later data are determined using date last normal menses began and date of first prenatal care visit. Data prior to 2006 used the month prenatal care began provided on the birth certificate. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	140
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Narrative:

Beginning April 1, 1999, eligibility levels for Medicaid and SCHIP were increased from 133% to 140% of the FPL for infants 0-1. Beginning July 1, 2000, eligibility levels for SCHIP were increased to 200% of the FPL. DOH programs, including the MCH programs and WIC, routinely identify and refer uninsured infants to the Medicaid/SCHIP programs for financial assistance for medical care.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	140

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	200

Narrative:
Beginning April 1, 1999, eligibility levels for Medicaid and SCHIP were increased from 133% to 140% of the FPL for children 1 to 19 years of age. Beginning July 1, 2000, eligibility levels for SCHIP were increased to 200% of the FPL. DOH programs, including the MCH programs and WIC, routinely identify and refer uninsured infants to the Medicaid/SCHIP programs for financial assistance for medical care.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	

Notes - 2010
Pregnant women are not eligible for SCHIP

Narrative:
Some pregnant women are eligible to receive full Medical Assistance while other pregnant women are only eligible for pregnancy-related services. The family income must be at or below 133% of FPL and less than $7,500 resources. DOH programs, including the MCH programs and WIC, routinely identify and refer uninsured pregnant women to the Medicaid program for financial assistance for medical care.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid	1	No

Eligibility or Paid Claims Files		
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
Key MCH program staff have direct access, with security blocks as needed, to information on infant birth certificates, WIC files, metabolic files and Perinatal Health Risk Assessment Survey data. This access allows the MCH program to obtain data as needed for program policy and planning. Additional information is available upon request from Medicaid to match to birth certificate data. Under a contract with SDAHO, the MCH program is able to obtain hospital discharge data, however the program does not have direct access to the data.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
BRFSS	3	Yes

Notes - 2010

Narrative:
The Tobacco Control Program (TCP) coordinates tobacco control activities within the DOH. TCP staff participate in MCH team meetings to communicate activity and progress. The TCP did receive additional funding for tobacco control programming as a result of passage of Initiated Measure 2 in November 2006 which raised the tax on tobacco products and directed a portion of the funds to the TCP. The TCP collaborates with the Department of Education (DOE) to collect tobacco usage data through the YRBS which is repeated every two years in South Dakota. The survey was administered to students in the spring of 2007.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The DOH priority needs are based on the needs assessment completed for the FY 2006 South Dakota MCH Block Grant application. Priority needs in South Dakota cross the four levels of the public health services pyramid. The DOH has identified the following MCH priority needs: (1) reduce unintended pregnancies; (2) reduce infant mortality; (3) improve pregnancy outcomes; (4) reduce morbidity and mortality among children and adolescents; (5) improve adolescent health and reduce risk taking behaviors (i.e., unintentional injuries, dietary habits, physical activity, tobacco use, alcohol/drug use); (6) improve the health of, and services for, CSHCN through comprehensive services and support; (7) improve and assure appropriate access to health services that are focused on families, women, infants, children, adolescents, and CSHCN; (8) improve state and local surveillance and data collection and evaluation capacity; and (9) reduce childhood obesity.

The priority setting process is an ongoing and evolving process. Systems development for women, infants, children, adolescents, and CSHCN is an integral part of the MCH planning process and includes analyzing current programs and services, identifying gaps in services, establishing appropriate goals and objectives, collaborating with partners, and establishing methods for monitoring and evaluating programs and services to ensure that goals and objectives are met.

The MCH team also initiated a MCH Assessment, Planning and Monitoring Process which is data driven, with the starting point of assessing the needs of the MCH population groups using Title V health status and system capacity indicators, performance measures, and other quantitative and qualitative data. The process focused on needs, priorities, targets, and activities -- not specific programs or individuals. The team discussed national and state performance measures, determining if objectives were met or unmet. Health system capacity, health status indicators, and data sets used were analyzed. Additional data sources to assist in assessment of each population group were identified. As a result of the process, a matrix was developed that linked needs, data sources, performance measures, and indicators relevant to the needs, linkages to Healthy People 2010 objectives, gaps in data or data needs, and identification of a lead agency. The MCH team then determined level of responsibility relative to the MCH program. This process allowed for the prioritization of needs for the population groups and the role of MCH in addressing them.

B. State Priorities

As a result of the MCH assessment, South Dakota has developed several performance measures that relate directly to identified priority needs. Priority needs in South Dakota, as well as the respective performance measures and activities that address these needs, cross the four levels of the core public health infrastructure pyramid -- direct services, enabling services, population-based services, and infrastructure building services.

Direct service interventions improve health status and reduce adverse outcomes. Since enabling services facilitate and enhance direct services, activities in both levels of the pyramid will address the state's priorities. There are several priority needs that primarily impact the population-based service level. In order to accomplish improvement in the state's priorities, there must be education and service interventions at both the direct and enabling service levels. Conversely, effective interventions at the direct and enabling service levels require population-based education and other activities. All state priority needs have elements of infrastructure building services. The development of an interagency collaborative infrastructure is critical to reducing barriers to care and improving health outcomes. Improved state and local surveillance, data collection and evaluation capacity facilitate data-driven decision making regarding allocation or resources and

strategies to address the priority needs. Coordination, quality assurance, standards development, and monitoring must accompany interventions to reduce barriers to care and improve and assure appropriate access to health services focused on families, women, infants, children, adolescents, and CSHCN.

SPM #1: Percent of women who smoked prior to pregnancy and report they stopped during pregnancy.
/2008/ This state performance measure has been discontinued. //2008//

SPM #2: The rate (per 1,000 live births) of children under age one who die as a result of Sudden Infant Death Syndrome.
SIDS is occurring over three times as much in the Native American population than in the White population. One of the most important things to help reduce the risk of SIDS is to place healthy babies on their backs when they sleep and reduce and/or avoid exposure to secondhand smoke. Education is an important piece to helping to reduce SIDS deaths among infants in the state. Activities related to this performance measure will impact infant mortality related to SIDS in the state.

SPM #3: Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.
Unintended pregnancies are associated with maternal health risk behaviors, low use of preventive health measures (e.g., early prenatal care), child abuse, and dependency on welfare. There is a greater risk for complications and poor pregnancy outcomes including infant mortality, birth defects, and low birth weight infants.

SPM #4: Percent of high school youth who self-report tobacco use in the past 30 days.
Smoking is responsible for one in six adult deaths in the U.S. and is the single most preventable cause of death. According to the 2003 YRBS, 60% of respondents have tried cigarette smoking with 18% of respondents having smoked a whole cigarette prior to age 13. Thirty percent of respondents smoked a cigarette during the past 30 days and 62% who have smoked during the past 12 months reported they have tried to quit smoking. Fifteen percent of respondents had used chewing tobacco or snuff during the past 30 days.
/2009/ The 2007 YRBS reports 55% of respondents have tried cigarette smoking with 17% of respondents having smoked a whole cigarette prior to age 13. Twenty-five percent of high school youth are current smokers (down from 28% in the 2005 report) and 62% of respondents who have smoked in the past 12 months reported they have tried to quit. In 2007, 11% reported spit tobacco use which is down from 13% in 2005. The TCP collaborates with DOE to collect tobacco usage data through YRBS and the survey is repeated every two year. The survey was last administered to students in the spring of 2007. //2009//

SPM #5: Percent of school-aged children and adolescents with a Body Mass Index (BMI) at or above the 95th percentile.
Obesity is a risk factor for many chronic medical conditions including cardiovascular disease, hypertension, diabetes, degenerative joint disease, and psychological problems. Overweight can result from excessive energy intake, decreased energy expenditure, or impaired regulation of energy metabolism. Activities include development of a system to assess and monitor obesity in school-aged children.

SPM #6: Percent of children age 2-5 who are overweight or obese.
Obesity is a risk factor for many chronic medical conditions including cardiovascular disease, hypertension, diabetes, degenerative joint disease, and psychological problems. Overweight can result from excessive energy intake, insufficient energy expenditure, or impaired regulation of energy metabolism. Weight-for-height during early infancy predicts weight-for-height during late infancy and childhood.
/2007/ This state performance measure is now NPM 14. //2007//

SPM #7: Percent of infants who are breastfed at least 6 months.
Breastfeeding provides the most complete nutrition for infants and has many benefits to both mother and infant including decreased new cases and severity of diarrhea, respiratory infections, and ear infections. Infants who are breastfed have less overweight and the overweight is improved the long the infant is breastfed.
/2007/ This state performance measure is now NPM 11. //2007//

/2007/ SPM #08: Percentage of mothers who breastfeed their infants at hospital discharge.
Breastfeeding provides the most complete nutrition for infants and has many benefits to both mother and infant including lower rates of infections, asthma, allergies, diabetes, childhood obesity, and SIDS.

SPM #9: Percent of mothers who achieve a recommended weight gain during pregnancy.
Gestational weight gain is an important determinant of fetal growth. Inadequate weight gain increases risk of inadequate fetal growth, low birth weight, and infant death. Excessive weight gain increases risk of excessive fetal growth leading to increased incidence of C-section. Risk of maternal complications such as hypertension are also increased. Maternal weight gain is susceptible to intervention and represents an avenue for prevention of poor birth outcomes. A woman with a normal BMI should gain 29 to 40 pounds; and those with a high BMI should gain 15 to 25 pounds. Excessive weight gain also is often retained by the mother thus contributing to adult obesity and high BMI for subsequent pregnancies.

SPM #10: Percent of infants exposed to secondhand smoke.
Infants exposed to secondhand smoke are at increased risk for developing respiratory infections, allergies, asthma, digestive difficulties, and SIDS. According to the 2005 South Dakota Perinatal Health Risk Assessment Survey, 85.4% of women who responded to the survey stated that smoking is not allowed at any time in the house or car. Only 70% of the respondents said that a physician, nurse or other health care professional had talked to them about how smoking around the baby could affect the baby's health. All pregnant women seen at CHN offices are risk assessed to determine past and current smoking behaviors as well as their level of exposure to secondhand smoke. Questions on the birth certificate related to smoking behaviors have been added this year. //2007//
/2009/ The 2007 Perinatal Health Risk Assessment Survey reports 90% of respondents indicated that there was not any smoking allowed at any time in the house or car, compared to 85.4% in 2005. Only 1.6% of respondents indicated smoking was allowed any time in the house or car. //2009//

South Dakota's State Outcome Measure addresses the Native American infant mortality rate for the state. The infant mortality rate is a traditional indicator of general health status. Native American infant mortality has been a long standing public health problem. Using a five-year rolling average, the discrepancy in Native American and white infant mortality has increased over the past five years from 2.30 in 1991 to 2.61 in 1996 while overall infant mortality rates for the state have decreased from 9.4 to 5.7.
/2009/ Using a five-year rolling average, the discrepancy in Native American and white infant mortality has increased over the past five years from 2.37 in 2002 to 2.23 in 2007 while overall infant mortality rates for the state have decreased from 6.5 to 6.4. //2009//
Since Native American live births compose 15 percent of the live birth cohort, South Dakota must reduce the Native America to white discrepancy in infant mortality to achieve significant improvements in infant mortality.
/2009/ OCHS will expand the Bright Start Home Visiting Program to the Pine Ridge Reservation by the fall of 2008. This site will start with one nursing FTE and there will be ongoing efforts to secure funding resources to increase services to Pine Ridge Reservation and potentially expand to other reservation sites. //2009//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	5	5	8	11	14
Denominator	5	5	8	11	14
Data Source					Metabolic Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
2006-2008 South Dakota Metabolic Screening Program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.

Notes - 2007
2005-2007 South Dakota Metabolic Screening Program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates all confirmed positive screens receive appropriate follow-up.

Notes - 2006
2004-2006 South Dakota Metabolic Screening Program data. Numerator and denominator are 3-year averages. Includes only resident confirmed cases. South Dakota law mandates that all confirmed positive screens must receive appropriate follow-up.

a. Last Year's Accomplishments
• Contracted with the University of Iowa Hygienic Laboratory (UHL) for the provision of newborn metabolic screening laboratory services in South Dakota for all mandated disorders including congenital hypothyroidism, galactosemia, phenylketonuria (PKU), hemoglobinopathies, biotinidase deficiency, congenital adrenal hyperplasia, amino acid disorders, fatty acid oxidation disorders, organic acidemias, and cystic fibrosis.
• Updated information links and resources on the DOH Newborn Screening website.
• Provided educational materials to birth hospitals regarding newborn screening specimen collection and submission to UHL.
• Collaborated with laboratory and health care providers to assure follow-up on infants with indeterminate or abnormal specimens.
• Provided follow-up to those infants without metabolic screening results through ongoing matching of birth certificates and laboratory reports.
• Collaborated with DSVR to link birth and death certificates with the laboratory results through

EVRSS for data collection and monitoring.
• Distributed brochure explaining Newborn Screening to hospitals, physicians, and other health care providers in the state.
• Distributed educational dvds regarding newborn screening to various hospitals, CHS offices, and Women's Centers across the state.
• Initiated a Long-Term Follow-Up (LTFU) program with four components -- database/registry, education, care coordination, and data collection.
• Sent quality assurance reports to submitting facilities comparing unacceptable specimen rates and turnaround times with State averages.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain/improve newborn metabolic screening data collection system.				X
2. Screen/provide necessary follow-up for required disorders.			X	
3. Verify notification of indeterminate and abnormal test results.	X			
4. Distribute newborn metabolic screening program brochure to healthcare providers.			X	
5. Link birth/death certificates with newborn screening laboratory results through EVRSS.				X
6. Update program manual as necessary and distribute to hospitals and healthcare providers in the state.				X
7. Maintain and update newborn screening program website.				X
8. Refer infants diagnosed with a metabolic disorder to CSHCN program.			X	
9. Collaborate with UHL to provide technical assistance to facilities and healthcare providers as need is identified.				X
10. Expand LTFU program for children residing in South Dakota identified with a metabolic disorder.			X	

b. Current Activities
• Providing ongoing technical assistance to hospitals/physician offices regarding process changes in newborn screening procedures with UHL.
• Collaborating with UHL and health care providers to assure follow-up on infants with indeterminate or abnormal specimens.
• Providing follow-up to those infants without metabolic screening results through ongoing matching of birth certificates and laboratory reports.
• Collaborating with DSVR to link birth certificates with the laboratory results through the EVRSS for data collection and monitoring.
• Strengthening relationships with medical specialists in South Dakota to assure appropriate follow-up and medical management for infants with positive screening results.
• Utilizing the UHL website to monitor indicators of quality such as turnaround times and poor quality specimen.
• Collaborating with the Regional Genetics and Newborn Screening Collaborative to identify the regional needs of improving access to newborn screening services.
• Expanded LTFU program to include all children residing in South Dakota identified with biotinidase deficiency, hemoglobinopathies, congenital adrenal hyperplasia, amino acid disorders, fatty acid oxidation disorders, organic acidemias, galactosemia, PKU, and congenital hypothyroidism.

c. Plan for the Coming Year

• Partner with UHL for the provision of newborn metabolic screening laboratory services in South Dakota for all mandated disorders.
• Update information links and resources on the DOH Newborn Screening website.
• Offer ongoing technical assistance to hospitals and physician offices regarding newborn screening.
• Collaborate with UHL and health care providers to assure follow-up on infants with indeterminate or abnormal specimens.
• Provide follow-up to those infants without metabolic screening results through ongoing matching of birth certificates and laboratory reports.
• Collaborate with DSVR to link birth certificates with the laboratory results through the EVRSS for data collection and monitoring.
• Distribute brochure explaining Newborn Screening to hospitals, physicians, and other health care providers in the state.
• Continue to strengthen relationships with medical specialists in South Dakota to assure appropriate follow-up and medical management for infants with positive screening results.
• Monitor indicators of quality such as turnaround times and poor quality specimen through utilization of the UHL website.
• Develop new partnerships to provide long-term follow up of infants with diagnosed disorders to assure those persons responsible for the care of the child are fully informed of current standards of medical management.
• Collaborate with the Regional Genetics and Newborn Screening Collaborative Region V to identify the regional needs of improving access to newborn screening services.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	60	95	96	96	98.5
Annual Indicator	94.3	96.0	96.0	98.5	96.4
Numerator	840	452	452	15977	15950
Denominator	891	471	471	16226	16554
Data Source					BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	97	97.5	97.5	98	98.5

Notes - 2008

2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of those respondents indicating they had a CSHCN, 96.4% reported they were satisfied with the

involvement you have had with your child's health care team in making decisions about what care is provided to your child.

Notes - 2007
2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN, 98.5% reported they were satisfied with the involvement you have had with your child's health care team in making decisions about what care is provided to your child.

Notes - 2006
2005/2006 South Dakota CSHCN survey

The DOH conducted a survey of parents of CSHCN in conjunction with SD Parent Connection from December 2005 through March 2006. Questions were asked to gather data pertaining to National Performance Measures addressing the CSHCN population. 96% of respondents answered yes to the question, "As parents, are you satisfied with the involvement you have had with your child's health care team in making decisions about what care is provided to your child?".

a. Last Year's Accomplishments
• Worked with CSHS regional office staff on care coordination and development of care plans in collaboration with families.
• Shared resources for families including support groups and transition planning resources.
• Collaborated with South Dakota's Parent Training Center (South Dakota Parent Connection) on parent training opportunities, FILE record system, Family to Family contacts, and other activities to support families.
• Shared training/conference opportunities with families and children that give families opportunities to meet other families in similar situations and identify ways to access different resources/programs such as the annual Dare to Dream Conference.
• Requested public input on administrative rules revisions impacting child/family involvement in the CSHS program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate on activities to support/empower parents.		X		
2. Identify training opportunities for families.		X		
3. Request public input prior to any adminsitrative rules revisions impacting child/family involvement in the CSHS program.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Identify and share new resources for families including support groups and transition planning resources.
• Collaborate with South Dakota Parent Connection on parent training opportunities, FILE record system, Family to Family contacts, and other activities to support families.
• Share training/conference opportunities with families and children that give families opportunities to meet other families in similar situations and identify ways to access different

resources/programs such as the annual Dare to Dream Conference.

c. Plan for the Coming Year

• Work with South Dakota Parent Connection to cross-train their staff and CSHS staff on opportunities each program offers to improve and maintain the training and systems building component of each program.
• Work with South Dakota Parent Connection to identify family member involvement/participation at the National Conference.
• Promote community training opportunities for families and providers on decision making and medical/home partnerships.
• Serve as an ad hoc member of the Family to Family Advisory Committee.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	55	84	91	91	97.3
Annual Indicator	83.0	90.8	90.8	97.3	97.3
Numerator	567	345	345	16631	14820
Denominator	683	380	380	17099	15226
Data Source					BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	97.3	97.4	97.4	97.5	97.5

Notes - 2008

2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of those respondents indicating they had a CSHCN and who had a primary doctor working with them to identify and assess the medical and non-medical needs to help the child and family achieve their goals, 97.3% rated the communication between the child's primary doctor and other health care provider as good, very good, or communication not needed.

Notes - 2007

2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN and who had a primary doctor working with them to identify and assess the medical and non-medical needs to help the child and family achieve their goals, 97.3% rated the communication between the child's primary doctor and other health care provider as good, very good, or communication not needed.

Notes - 2006

2005/2006 South Dakota CSHCN survey

The DOH conducted a survey of parents of CSHCN in conjunction with SD Parent Connection from December 2005 through March 2006. Questions were asked to gather data pertaining to National Performance Measures addressing the CSHCN population. Of the respondents that answered yes to the question, "Does your child's primary doctor work with you to identify and access all the medical and non-medical services needed to help your child and family achieve their goals?", 90.8% rated the communication between their child's primary doctor and other health care providers about their child's care as "good, very good or communication not needed".

a. Last Year's Accomplishments

• Networked with providers and families to address services and assistance available under CSHS.
• Provided care coordination, clinical services, and/or financial assistance to children with chronic medical conditions and their families through CSHS.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide care coordination services to children with chronic medical conditions.		X		
2. Network with providers and families on provision of services.				X
3. Provide financial assistance for medical and mileage expenses to ensure comprehensive care		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Discontinued regional offices effective August 1, 2008 and moved financial/eligibility determination and processes to the state office.
• Developed new brochure and logo for CSHS program -- Health KiCC (Better Health for Kids with Chronic Conditions).
• Providing e-mail address for families to access assistance via the internet and enhancing www.children.sd.gov website to include application package.
• Contracting for care coordinator positions (effective August 1, 2008) to assist families in receiving coordinated, comprehensive care.
• Networking with providers and families to address services and assistance available under CSHS.

c. Plan for the Coming Year

• Provide financial assistance for medical and mileage expenses to appointments to ensure ongoing, comprehensive care.
• Provide care coordination services to children with chronic medical conditions.
• Network with providers and families to address services and assistance available under CSHS.
• Maintain e-mail access and website.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	61	78	69	69	89.7
Annual Indicator	77.5	69.2	69.2	89.6	91.0
Numerator	707	326	326	16040	16622
Denominator	912	471	471	17900	18267
Data Source					BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	91	91	91	91	91

Notes - 2008
2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of those respondents indicating they had a CSHCN, 91% reported they felt they had adequate health insurance.

Notes - 2007
2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN, 89.6% reported they felt they had adequate health insurance.

Notes - 2006
2005/2006 South Dakota CSHCN survey data.

The DOH conducted a survey of parents of CSHCN in conjunction with SD Parent Connection from December 2005 through March 2006. Questions were asked to gather data pertaining to National Performance Measures addressing the CSHCN population. 69.2% of respondents answered yes to the question, "Do you feel you have adequate health insurance?".

The small numbers tend to produce rates with more variability than larger numbers due to chance variations. No adjustments will be made in the Annual Performance Objective until a definite trend can be identified.

a. Last Year's Accomplishments
• Assisted in identification and referral of CSHCN and their families and facilitated application to Medicaid, SCHIP, and SSI as appropriate.
• Provided care coordination, clinical services, and/or financial assistance to children with chronic medical conditions and their families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide financial assistance for services for CSHCN.		X		
2. Assist in the identification and referral of CSHCN and their families and facilitate their application to Medicaid, SCHIP, and SSI.		X		
3. Identify new assistance programs available for families.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Providing financial assistance for services for CSHSN; financial assistance was increased to 250% of FPL and no cost share with all eligible families receiving 100% coverage after all other third payers.
• Assisting in identification and referral of CSHCN and their families and facilitating application to Medicaid, SCHIP, and SSI as appropriate. CSHS requires all families applying for financial assistance to first apply to Medicaid which has resulted in more families accessing Medicaid assistance.
• Linking families to other resources that can assist with needs not being met by their public or private health care coverage (i.e., prescription assistance, community-specific assistance programs).
• Ensuring CSHS staff are aware of assistance program available to families such as the SD Risk Pool (insurance for individuals who have lost insurance coverage through no fault of their own), Respite Care Program, Family Support Services, and Birth to 3 Connections (early intervention program).

c. Plan for the Coming Year

• Collaborate with DHS and SSA to facilitate action on transmittals from Disability Determination Services.
• Collaborate with DHS (Divisions of Mental Health, Developmental Disabilities, and Vocational Rehabilitation), SSA, DSS (Medicaid and SCHIP), and DOE (Birth to 3) to assist in the provision of coverage and services for CSHCN.
• Identify possible assistance programs/resources available across the state.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	75.4	76	76	76	88.3
Annual Indicator	69.6	74.6	74.6	88.0	94.3
Numerator	595	343	343	13496	14097

Denominator	855	460	460	15333	14955
Data Source					BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	94.3	94.5	94.5	94.5	94.5

Notes - 2008
2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of those respondents indicating they had a CSHCN, 94.3% reported community-based services used were organized and easy to use "sometimes" or "always".

Notes - 2007
2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN, 88.1% reported community-based services used were organized and easy to use "sometimes" or "always".

Notes - 2006
2005/2006 South Dakota CSHCN survey

The DOH conducted a survey of parents of CSHCN in conjunction with SD Parent Connection from December 2005 through March 2006. Questions were asked to gather data pertaining to National Performance Measures addressing the CSHCN population. 74.6% of respondents answered "sometimes" or "always" to the question, "Do you feel the community-based services you use are organized and easy to use?".

a. Last Year's Accomplishments
• Provided care coordination, clinical services, and/or financial assistance to children with chronic medical conditions and their families through CSHS.
• Received referrals from physicians, schools, parents, hospitals, and other agencies.
• Assisted in the provision of needed services for specialty care and/or primary care follow-up for CSHCN in their home community.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to improve coordination of care for CSHCN.				X
2. Continue networking efforts to ensure awareness of CSHS.				X
3. Provide care coordination services to children with chronic medical conditions.		X		
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

• Improving coordination of care by establishing linkages with other agencies, programs, and providers via conferences, task forces, workgroups, and program planning committees.
• Providing care coordination, clinical services, and/or financial assistance to children with chronic medical conditions and their families through CSHS.
• Receiving referrals from physicians, schools, parents, hospitals, and other agencies.
• Assisting in the provision of needed services for specialty care and/or primary care follow-up for CSHCN in their home community.
• Developed new brochure and logo for CSHS program -- Healthy KiCC (Better Health for Kids with Chronic Conditions).
• Providing e-mail address for families to access assistance via the internet and enhancing www.children.sd.gov website to include application package.

c. Plan for the Coming Year

• Develop and implement new media strategies to address CSHS changes including increased financial assistance with family income now up to 250% of FPL and no cost share.
• Communicate with all medical providers so they are aware of CSHS program and the services/ assistance available to their patients.
• Reemphasize the role of the primary care provider in the care of the CSHCN population regarding the medical home, coordination of care, and needed communication between all providers.
• Maintain e-mail access and website.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6	50	55	55	86.2
Annual Indicator	49.6	53.5	53.5	86.2	86.9
Numerator	211	69	69	5434	4202
Denominator	425	129	129	6307	4836
Data Source					BRFSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86.9	86.9	86.9	86.9	87

Notes - 2008

2008 South Dakota BRFSS survey weighted data. The DOH added questions to the BRFSS survey pertaining to CSHCN. Questions were asked to gather data pertaining to the National Performance Measures addressing the CSHCN population. There were 6,981 adults surveyed in 2008 and of those 1,847 households had at least one child less than 18 years of age and of those children, 170 were CSHCN. Of the households surveyed, 1,843 provided appropriate data to be weighted and 170 of the households with CSHCN provided appropriate data to be weighted. Of those respondents indicating they had a CSHCN, 86.9% reported the services their child 12-17 years of age received helped them transition to adult health care, work, and independence.

Notes - 2007
2007 South Dakota BRFSS survey weighted data. Of those respondents indicating they had a CSHCN, 86.2% reported the services their child 12-17 years of age received helped them transition to adult health care, work, and independence.

Notes - 2006
2005/2006 South Dakota CSHCN survey

The DOH conducted a survey of parents of CSHCN in conjunction with SD Parent Connection from December 2005 through March 2006. Questions were asked to gather data pertaining to National Performance Measures addressing the CSHCN population. Of the surveys representing children/adults age 13-20 years of age, 54.3% answered yes to the question, "Do you feel the services your child receives have helped them transition to adult health care, work and independence?"

a. Last Year's Accomplishments
• Provided care coordination, clinical services, and/or financial assistance to children with chronic medical conditions and their families through CSHS.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist adolescent CSHCN identify/address needs related to transition to adult life.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Assisting adolescent CSHCN and their families prior to age 18 identify areas of need related to transition to all aspects of adult life through care coordination activities and resource identification. The CSHS program works with CSHCN and their families up to the child's 21st birthday.

c. Plan for the Coming Year
• Provide financial assistance under CSHS with family income up to 250% of FPL with no cost share.
• Identify additional training and resources to assist adolescents and their families in planning for

their adult care.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	83	84	85	86	75
Annual Indicator	80.3	72.8	72.8	74.9	84.7
Numerator	8390	10811	11626	11798	8002
Denominator	10448	14856	15967	15742	9443
Data Source					SD Immunization Information System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	86	86.5	87	87.5	88

Notes - 2008
2008 South Dakota Immunization Information System data

Notes - 2007
2007 South Dakota Immunization Information System data

Notes - 2006
2006 South Dakota Immunization Information System data.

a. Last Year's Accomplishments
• Served as a "universal-select" vaccine provider. The Immunization Program distributed diphtheria, tetanus, acellular pertussis, Haemophilus influenza B, measles, mumps, rubella, polio, pneumococcal conjugate, varicella, and hepatitis B vaccines for children 18 years and younger.
• Offered free HPV vaccine to all females 12 years of age.
• Offered free influenza vaccine to all children aged 6 months through 18 years.
• Maintained the linkage between WIC and Immunization programs to improve immunization assessment and referral for any infant/child seeking services through OCHS/PHA offices.
• Completed audits of all South Dakota kindergarten and transfer students' immunization records to assure compliance with state immunization requirements for school entry; 95% had the immunizations required by law to enter school for 2008-09.
• Provided technical assistance and resources to seven active local community immunization coalitions which educate the community and sponsor activities to increase age-appropriate immunizations.
• Provided childhood vaccine and vaccination education to physicians, nurses, and other health care professionals.

• Maintained the federal Vaccines for Children (VFC) program to ensure that children who are Medicaid-enrolled, American Indian, uninsured, and under-insured received immunizations in a timely manner.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue as "universal-select" vaccine provider and distribute federally-funded vaccine.			X	
2. Promote childhood immunizations.			X	
3. Purchase Hepatitis A vaccine to be available to all children 1-18 years of age.			X	
4. Promote meningococcal vaccine to all VFC-eligible 11-12 year olds and those adolescents entering their freshman year of high school or college.			X	
5. Purchase RotaTeq for all VFC-eligible infants.			X	
6. Promote the birth dose of Hepatitis B vaccine.			X	
7. Collaborate with DSS to assess immunization status of children receiving public assistance.				X
8. Promote immunization data entry into SDIIS.				X
9. Provide support and resources to community immunization coalitions.				X
10. Add immunization materials to the Bright Start Welcome Box.			X	

b. Current Activities

• Purchasing Varicella vaccine; 2nd dose is required for school entry.
• Continuing as a "universal-select" vaccine provider to distribute federally-funded vaccine free of charge.
• Offering free HPV vaccines to all 12-year-old females and VFC eligible females age 11-18 years.
• Offering Menactra to underinsured children age 11-18 years through OCHS sites which are designated as rural health clinics.
• Providing influenza vaccinations for children age 6 months through 18 years.
• Offering schools, universities/colleges, tribal colleges, and Head Starts access to SDIIS.
• Distributing immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.
• Accessing immunization status of infants and children served by TANF and Medicaid, those receiving home visits through Bright Start, and those receiving services through the Dakota Smiles Mobile Dental Program.
• Developing and refining local agency plans to improve the assessment, administration, and referral for immunizations.
• Providing technical assistance and resources to seven active immunization coalitions.
• Conducting annual audits on immunization records for all kindergarten and transfer students.
• Offering immunization incentives to vaccine providers, parents, and children.
• Expanding communication with vaccine providers and offering training for new and existing vaccine providers.

c. Plan for the Coming Year

• Continue as a "universal-select" vaccine provider and distribute federally-funded vaccine free of charge through ODP.
• Utilize state funds to purchase Varicella and influenza vaccine.

• Offer HPV vaccine to all females 12 years of age.
• Serve on local community immunization workgroups to assess immunization needs and facilitate development of plans to immunize children.
• Encourage Immunization Program enrollment for all South Dakota birthing hospitals to promote the birth dose of Hepatitis B.
• Distribute immunization materials to hospitals, clinics, DOH field offices, day cares, schools, Head Starts, and other interested organizations.
• Access immunization status of infants and children served by TANF and Medicaid, those receiving home visits through Bright Start, and those receiving services through the Dakota Smiles Mobile Dental Program.
• Continue to develop and refine local agency plans to improve assessment, administration, and referral for immunizations. The local plan focuses on the WIC/Immunization linkage and any infant/child seeking services through OCHS/PHA offices.
• Collaborate with DSS to include immunization information to the Bright Start Welcome Boxes.
• Provide technical assistance and resources to seven active local community immunization coalitions.
• Conduct annual audits of immunization records for all kindergarten and transfer students.
• Promote immunization data entry into SDIIS.
• Offer immunization incentives to vaccine providers, parents, and children.
• Offer training for new and existing vaccine providers.
• Maintain Blast Fax and Listserv to communicate with vaccine providers.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	16	15	19	18	18
Annual Indicator	17.4	19.8	18.7	19.8	20.8
Numerator	299	337	318	334	345
Denominator	17165	16982	16982	16828	16591
Data Source					Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	19	19	18.5	18	18

Notes - 2008
2008 South Dakota birth certificate data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota birth certificate data. Rate based on 2006 South Dakota population estimate. In analyzing the trend of increasing birth rate for teenagers aged 15-17 years, the rate was compared for Native Americans and Whites. The birth rate for Native American teens remains greater than for Whites. The number of births to Native American teenagers is approximately the same while the total number of White teenagers is 6 times the total number of Native American

teenagers. In analyzing the rates by these two races, it is apparent there is an increasing trend for both races but the increase is greater for Native Americans. In 2003 the rate for Native Americans was 55.0 births per 1,000 female teenagers and in 2007 this has increased to 62 births. This compares to a rate of 8.7 births per 1,000 White female teenagers in 2003 increasing to 11.7 in 2007. While services area available on four of the nine reservations and through Urban Indian Health in Aberdeen, Pierre, and Sioux Falls, very few Native American teenagers access family planning services through South Dakota Family Planning. The Family Planning Program has submitted a grant application to fund new partnerships on the Pine Ridge and Standing Rock Reservations.

Notes - 2006
2006 South Dakota birth certificate data. Rate based on 2005 South Dakota population estimate.

The Annual Performance Objective is consistent with the DOH 2010 Initiative goal to reduce the teen pregnancy rate for teens age 15-17 to 15.0 by 2010.

a. Last Year's Accomplishments
• Provided family planning services to 3,043 adolescents age 19 and under during CY08; approximately 42.6% of adolescents seen were 17 years of age or younger.
• Provided community/school education services related to reproductive health to 4,164 adolescents in CY08.
• Provided community/school abstinence education programs to 6,260 youth, young adults, and parents during FFY08.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Negotiate new/monitor existing contracts for the provision of abstinence education.				X
2. Provide reproductive health services to adolescents.			X	
3. Provide community/school education programs related to reproductive heatlh upon request.			X	
4. Collaborate with community-based organizations to identify new strategies to reduce the rate of births for adolescents.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Providing family planning services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.
• Providing community/school education services related to reproductive health upon request to adolescents.
• Providing community/school abstinence education programs upon request to adolescents age 19 and younger.

c. Plan for the Coming Year

• Provide family planning services to adolescents including counseling, education, medical exams, STD screening, and contraceptive supplies.
• Provide community/school education services related to reproductive health upon request to adolescents.
• Provide community/school abstinence education programs upon request to adolescents age 19 and younger.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	50	50	55	55	61.5
Annual Indicator	49.4	49.4	61.1	61.1	61.1
Numerator	351	351	392	392	392
Denominator	710	710	642	642	642
Data Source					SD Oral Health Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	61.5	61.5	62	62	62

Notes - 2008
2006 South Dakota oral health survey data.

Notes - 2007
2006 South Dakota oral health survey data.

39% of children in the 2006 oral health survey did not have dental sealants. In 2006, 61% of the 3rd grade children screened had dental sealants compared to 50% in 2003. 70% of American Indian children had dental sealants in 2006. During the last three years, the prevalence of dental sealants has increased dramatically in South Dakota. These comparisons indicate a significant improvement in the percentage of children with dental sealants.

The small numbers tend to produce rates with more variability than larger numbers due to chance variations. No adjustments will be made in the Annual Performance Objective until the next oral health survey to determine if a definite trend can be identified.

Notes - 2006
2006 South Dakota oral health survey data.

39% of children in the 2006 oral health survey did not have dental sealants. In 2006, 61% of the 3rd grade children screened had dental sealants compared to 50% in 2003. 70% of American Indian children had dental sealants in 2006. During the last three years, the prevalence of dental sealants has increased dramatically in South Dakota. These comparisons indicate a significant

improvement in the percentage of children with dental sealants.

The small numbers tend to produce rates with more variability than larger numbers due to chance variations. No adjustments will be made in the Annual Performance Objective until a definite trend can be identified.

a. Last Year's Accomplishments

• Published 2006 Oral Health Survey Report which provides data on oral health in South Dakota.
• Provided educational materials and resources on oral health through dental clinics, DOH offices, Head Start/Early Head Start, FQHCs, health fairs, professional meetings/conferences, etc.
• Participated on the Oral Health Coalition Steering Committee and subcommittees.
• Facilitated oral health education/training opportunities for staff with DOH, CHCs, Head Starts, day cares, and other health providers.
• Continued discussions with Delta Dental, SDDA, and ORH regarding options for improving access to oral health care for South Dakota children.
• Partnered with Delta Dental on the Care Mobile project to provide educational materials for their dental patients and families.
• Served on Advisory Board for the Partner for Prevention project to address oral health training for non-dental health professionals.
• Developed and distributed brochure about the hazards of consuming sweetened beverages.
• Partnered with Oral Health Coalition to air oral health messages on tv/radio statewide including messages specifically targeting the Native American population.
• Partnered with DSS to provide oral health information in the Bright Start Welcome Box.
• Provided oral health information for the CSHP electronic newsletter "NewsInfused".

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide "train the trainer" oral health education to Head Start/Early Head Start staff, day care providers, DOH regional managers, and CHNs.				X
2. Provide oral health messages for tv/radio statewide.			X	
3. Update the DOH oral health webpage as needed.				X
4. Partner with ORH to conduct community dental needs assessments for the Dental Tuition Reimbursement Program.				X
5. Serve on the advisory board for the Dakota Smiles Mobile Dental Program.				X
6. Provide oral health brochure in Bright Start Welcome Box.			X	
7. Participate on Oral Health Coalition Steering Committee and subcommittees.				X
8. Distribute oral health resources for healthcare providers and child advocates at various health events, conferences, association meetings, health fairs, etc.			X	
9. Partner with Delta Dental to provide oral health resources for patients served by the Dakota Smiles Mobile Dental Program.				X
10. Collaborate with AATCHB oral health program staff to provide oral health resources for the Native American population.				X

b. Current Activities

• Participating on the Oral Health Coalition steering committee.
• Facilitating oral health education/training opportunities and resources for DOH, CHCs, Head Starts/Early Head Start, day cares, and other health providers.
• Working with SDDA and Delta Dental to distribute information to dental/medical professionals

about oral health-related performance measures, HP2010, and collection of data to measure progress towards objectives.
• Continuing discussions with Medicaid, Delta Dental, SDDA, and ORH regarding options for improving access to oral health care for children.
• Updating DOH oral health website as needed.
• Partnering with ORH to conduct community dental needs assessments for the Dental Tuition Reimbursement Program.
• Participating on Advisory Board for the Dakota Smiles Mobile Dental Program and providing financial support for the mobile clinics.
• Providing "train the trainer" oral health materials for the DOH regional managers and CHNs.
• Collaborating with IHS and AATCHB to distribute oral health resources to the Native American population.
• Partnering with DSS to provide oral health information in the Bright Start Welcome Box.
• Providing oral health information for "NewsInfused".
• Exploring conducting a dental assessment of Head Start children.
• Contracting with regional dental hygienists to provide oral health education to local MCH populations and tobacco cessation training for dental professionals

c. Plan for the Coming Year
• Participate on the Oral Health Coalition steering committee.
• Facilitate oral health education/training opportunities to update staff with DOH, CHCs, Head Starts, day cares, and other health providers.
• Work with SDDA and Delta Dental to distribute information to dental/medical professionals about oral health-related performance measures, HP2010, and collection of data to measure progress towards objectives.
• Continue discussions with Medicaid, Delta Dental, SDDA, and ORH regarding options for improving access to oral health care for children in South Dakota.
• Updating DOH oral health website as needed.
• Partner with ORH to conduct community dental needs assessments for the Dental Tuition Reimbursement Program.
• Provide educational materials and resources on oral health through dental clinics, DOH offices, Head Start/Early Head Start, FQHCs, health fairs, day care providers, professional meetings/conferences, etc.
• Participate on Advisory Board for the Dakota Smiles Mobile Dental Program and provide financial support for the mobile clinics; provide oral health educational materials for distribution to Dakota Smiles patients and their families.
• Contract with Delta Dental to fund the Dakota Smile sealant program and site partner fees for Native American communities.
• Provide "train the trainer" oral health materials for DOH regional managers and CHNs.
• Partner with Head Start/Early Head Start to provide oral health training and educational resources for health specialists and teachers.
• Collaborate with IHS and AATCHB to distribute oral health resources to the Native American population in South Dakota.
• Partner with DSS to provide oral health information in the Bright Start Welcome Box.
• Provide oral health information for "NewsInfused".
• Conduct Basic Screening Survey of third grade students.
• Contract with USD to conduct sealant programs and preventive interventions for underserved populations.
• Contract with Sisseton-Wahpeton Oyate to enhance their Cavity Free by 2-0-1-3 program.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	9.5	10	10	9.5	5.1
Annual Indicator	10.7	10.3	7.1	5.1	3.1
Numerator	17	16	11	8	5
Denominator	158201	155916	155916	156390	161819
Data Source					Death Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3	3	3	3	3

Notes - 2008
2006-2008 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2006-2008 South Dakota population estimates.

Notes - 2007
2005-2007 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2004-2006 South Dakota population estimates.

Notes - 2006
2004-2006 South Dakota death certificate data. Numerators and denominators are 3-year averages. Rates are based on 2003-2005 South Dakota population estimates.

The death rate for unintentional injuries among children aged 14 years and younger continues to decline. DOH programs work with the clients they serve, especially in WIC, Baby Care and Bright Start, to educate parents about the importance of using a car seat, booster seats and/or seat belts. The Governor's Project 8 is the state's new goal to keep kids safe by making sure they are in the best child seat for their height and weight, until they are at least 8 years old. The program is a collaborative effort between the South Dakota Department of Public Safety and DSS. Project 8 holds free child safety seat check up events across the state to help with demonstrating and educating adults on the proper way to install child safety seats.

The small numbers tend to produce rates with more variability than larger numbers due to chance variations. No adjustments will be made in the Annual Performance Objective until a definite trend can be identified.

a. Last Year's Accomplishments
• Promoted community awareness campaigns designed to increase seat belt use.
• Attended the third annual South Dakota Safety Conference to promote roadway safety.
• Participated in quarterly Roadway Safety Committee meetings to discuss information about highway safety priorities, active state/local projects, and opportunities for partnership.
• Promoted "Parents Matter" campaign which promotes anti-drinking and driving with youth; the program was expanded from 15 school districts to 132 districts across the state.
• Collaborated with DSS on the Project 8 Program which provides a coordinated statewide system of child safety seat education and inspection in South Dakota; 4,284 car seats were distributed to eligible families along with instructions on proper installation techniques; 2,939

additional car seats were inspected of which 86% were installed incorrectly; 112 public education events were held reaching over 7,400 individuals.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with local advocates, law enforcement, and emergency responders statewide to enhance public awareness and promote the use of seatbelts.			X	
2. Participate in Roadway Safety Committee to improve roadway safety.				X
3. Attend South Dakota Safety Conference to promote roadway safety.				X
4. Collaborate with prevention agencies to address underage drinking and impaired driving.				X
5. Promote the Project 8 Program which provides a coordinated statewide system of child safety seat education and inspection.			X	
6. Promote the Safe Routes to Schools Program which provides funding to school districts to improve safety concerns for children walking and biking to school.			X	
7.				
8.				
9.				
10.				

b. Current Activities

• Providing training for elementary and middle school teachers on the LifeSkills curriculum which provides education on alcohol, tobacco and other drugs as well as healthy life choices.
• Promoting seatbelts and anti-drinking and driving through statewide media campaigns.
• Participating on Roadway Safety Committee which meets quarterly to discuss roadway safety issues including drivers' education, drunk driving prevention, and motorcycle safety.
• Supporting Safe Ride Program which promotes anti-drinking and driving in four South Dakota communities.
• Supported legislation during 2009 legislative session to establish a primary seat belt law (the legislation failed).

c. Plan for the Coming Year

• Support Parents Matter campaign which promotes anti-drinking and driving in 132 school systems and communities in the state.
• Support statewide high visibility enforcement campaigns promoting seat belt use.
• Promote the Project 8 Program.
• Participate in quarterly Roadway Safety Committee meetings to discuss information about highway safety priorities, active state and local projects, and opportunities for partnership and share information from committee with DOH staff.
• Participate in annual Safety Conference.
• Support Safe Routes to Schools program which provides funding to schools to increase safety of children walking or biking to school.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			43	43	44
Annual Indicator		34.7	38.8	40.5	38.1
Numerator					
Denominator					
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	44	44	44	44	44

Notes - 2008
2008 National Immunization Survey (NIS) data. Numerator and denominator are not available.

Notes - 2007
2007 National Immunization Survey data. Numerator and denominator are not available.

The percentage of mothers who breastfeed their infants at 6 months of age shows upward trend. Even though none of the years are significantly different, data still indicates an upward trend in the percent of breastfeeding.

Notes - 2006
2005 National Immunization Survey (NIS) data. Numerator and denominator are not available.

Sample sizes appearing in the 2005 NIS breastfeeding tables are slightly smaller than the numbers published in other NIS publications due to the fact that in the DNPA breastfeeding analyses, the sample was limited to records with valid responses to the breastfeeding questions.

a. Last Year's Accomplishments
• Participated on the SD Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion.
• Provided education and support to mothers in the Bright Start nurse home visiting, WIC, and Baby Care programs to encourage continued breastfeeding.
• Provided information to health professionals, hospitals, work sites, and public promoting breastfeeding.
• Updated breastfeeding information on the DOH and healthysd.gov websites to promote breastfeeding to parents, healthcare providers, and work sites.
• Developed, purchased, and distributed materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.
• Promoted continuation of breastfeeding to reduce overweight during childhood.
• Implemented a Breastfeeding Peer Counselor Program in WIC to work with pregnant and breastfeeding clients in Beadle, Brookings, Butte, Davison, and Yankton counties to provide education and support breastfeeding. Breastfeeding peer counselors were trained using the

Loving Support Breastfeeding Peer Counselor program and how they can work as a team to educate and support breastfeeding WIC participants.
• Provided training on "Breastfeeding -- Answers for the Anxious" at the WIC staff training in July 2008; training was geared to assist healthcare providers address breastfeeding concerns heard from new mothers to improve breastfeeding duration rates.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participate on the South Dakota Breastfeeding Coalition.				X
2. Educate mothers in various DOH programs on the benefits of breastfeeding and provide support/encouragement to initiate and continue breastfeeding.			X	
3. Provide information to health professionals, hospitals, worksites, and public promoting breastfeeding.				X
4. Update breastfeeding information on healthysd.gov and DOH websites.				X
5. Develop, purchase, and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.			X	
6. Promote continuation of breastfeeding to reduce overweight during childhood.				X
7. Address breastfeeding environment and support communities.				X
8. Develop and implement a statewide plan to improve breastfeeding rates.				X
9.				
10.				

b. Current Activities
• Participating on the SD Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion.
• Providing education and support to mothers in the Bright Start nurse home visiting, WIC, and Baby Care programs to encourage continued breastfeeding.
• Providing information to health professionals, hospitals, work sites, and the public promoting breastfeeding.
• Updating breastfeeding information on the DOH and healthysd.gov websites to promote breastfeeding.
• Developing, purchasing, and distributing materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.
• Working to reduce barriers to breastfeeding, particularly in the workplace.
• Providing a Breastfeeding Peer Counselor Program to pregnant and breastfeeding WIC clients in Beadle, Butte, Davison, and Charles Mix counties to provide education and support breastfeeding.
• Developing local coalitions to address breastfeeding environment and support in communities as well as provide resources to educators of prenatal and breastfeeding classes.
• Developing and implementing a statewide plan to improve breastfeeding rates.

c. Plan for the Coming Year
• Participate on the SD Breastfeeding Coalition to provide a networking system for breastfeeding education/promotion and to promote World Breastfeeding Week.
• Educate and support mothers in the Bright Start nurse home visiting, WIC, and Baby Care programs to encourage continued breastfeeding.

• Provide information to health professionals, hospitals, work sites, and the public promoting breastfeeding.
• Update breastfeeding information on the DOH and healthysd.gov websites to promote breastfeeding to parents, healthcare providers, and work sites.
• Develop, purchase, and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.
• Promote continuation of breastfeeding to reduce overweight during childhood.
• Provide a Breastfeeding Peer Counselor Program to pregnant and breastfeeding WIC clients in Beadle, Butte, Davison, Charles Mix, Minnehaha, and Pennington counties to provide education and support breastfeeding.
• Develop local coalitions to address breastfeeding environment and support in communities as well as provide resources to educators of prenatal and breastfeeding classes.
• Develop and implement a statewide plan to improve breastfeeding rates.
• Provide training on breastfeeding "Answers for the Anxious" for local agencies through the WIC all staff meeting; training is geared to assist healthcare providers address breastfeeding concerns often heard from new mothers to improve breastfeeding duration rates.
• Implement new WIC food package which includes more foods for breastfeeding mothers to promote breastfeeding initiation, exclusivity, and duration; new foods include more fish, fresh fruits and vegetables, and whole grain options.
• Focus on pregnant women within the WIC program to encourage and demonstrate benefits of breastfeeding to increase initiation, exclusivity, and duration rates.
• Set statewide and local agency goals to increase initiation and duration of breastfeeding through nutrition education and marketing plans, state plan goals and objectives, and the Statewide Nutrition Action Plan.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	90	92	93	97.5
Annual Indicator	88.0	91.7	96.8	97.3	98.0
Numerator	10385	10961	11992	12475	12374
Denominator	11805	11958	12386	12815	12631
Data Source					Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	98	98

Notes - 2008
2008 South Dakota Newborn Hearing Screening Program data.

Notes - 2007
2007 South Dakota Newborn Hearing Screening Program data.

Notes - 2006
2006 South Dakota Hearing Screening Program data.

There was an increase in the percentage of infants screened prior to hospital discharge because the second largest hospital in South Dakota now does screenings prior to hospital discharge as part of their standard of care.

The small numbers tend to produce rates with more variability than larger numbers due to chance variations. No adjustments will be made in the Annual Performance Objective until a definite trend can be identified.

a. Last Year's Accomplishments
• Collaborated with hospitals to ensure all babies born in South Dakota are screened for hearing impairment before 1 month of age, evaluation from a diagnostic audiologist by 3 months of age (if needed), and intervention by 6 months of age (if needed).
• Provided training to hospitals receiving state-owned hearing screening equipment.
• Distributed educational materials regarding causes of infant hearing loss and language/hearing development milestones to appropriate facilities statewide.
• Collaborated with DSVR on EVRSS to successfully link birth records with infant hearing screening for all infants born in the state; EVRSS allows for tracking of these infants for follow-up, confirmatory testing, and treatment and is linked with hospitals, physician clinics, and audiologists who provide follow-up and diagnostic services to the infants.
• Utilized Birth Certificate Worksheet to collect data on risk factors that may contribute to late-onset hearing loss.
• Began development of a process to exchange hearing screening results for those infants born in South Dakota but who are residents of another state.
• Ordered and distributed video tapes explaining the Newborn Hearing Screening program in English and Spanish closed caption as well as American Sign Language.
• Purchased and distributed hearing screening equipment and provided training for Birth to 3 staff to screen those children they serve for hearing loss.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensure infants receive timely hearing screening, evaluation, and intervention.			X	
2. Provide training for facilities with state-owned hearing screening equipment.				X
3. Distribute educational materials regarding causes of infant hearing loss and language/hearing development milestones to appropriate facilities.			X	
4. Collaborate with DSVR on EVRSS to link birth records with infant hearing screening data for all infants born in the state.				X
5. Utilize Birth Certificate Worksheet to collect data on risk factors that may contribute to late-onset hearing loss.				X
6. Work with other states to exchange hearing screening results.				X
7. Distribute hearing screeners and provide training to Early Head Start Programs to screen those children they serve for hearing loss.				X
8.				

9.				
10.				

b. Current Activities

• Collaborating with facilities to ensure all babies born in South Dakota receive appropriate hearing screening, evaluation and intervention.
• Exchanging results with other states for infants born in South Dakota but who are residents of another state.
• Utilizing Birth Certificate Worksheet to collect data on risk factors that may contribute to late-onset hearing loss.
• Providing training to hospitals receiving state-owned hearing screening equipment.
• Providing technical assistance to facilities on entering screening, rescreening, medical evaluation, and diagnostic audiological results into EVRSS.
• Providing educational materials in the Bright Start Welcome Box regarding late-onset hearing loss
• Conducting statewide media campaign (i.e., tv, radio, newspaper, on-line) explaining the 1-3-6 hearing screening process.
• Updating the Newborn Hearing Screening website with current information.
• Working with Early Head Start program to use hearing screeners previously located within Birth to 3 to monitor, gather screening results, and provide follow-up for children served by Early Head Start.

c. Plan for the Coming Year

• Collaborate with facilities to ensure all babies born in South Dakota receive appropriate hearing screening, evaluation, and intervention
• Work with other states to exchange results for infants born in South Dakota but who are residents of another state.
• Monitor and provide technical assistance on newborn hearing screening data entry into EVRSS.
• Provide training to and monitor hospitals receiving state-owned hearing screening equipment.
• Implement and monitor the tracking of infants with possible hearing loss with their screener, physician, diagnostic audiologist, and Birth to 3 program.
• Refer infants with possible hearing loss to the Birth to 3 program for early intervention services and funding.
• Distribute Newborn Hearing Screening materials as requested.
• Expand public/patient education efforts to reach those who do not have computer access.
• Explore creation of a tracking system for those infants identified through EVRSS as being a high risk for late-onset hearing loss.
• Provide technical assistance and explore possibility of creating a tracking system with EVRSS for those infants identified through the Early Head Start program.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	4	4	3.3	3.2	2.7
Annual Indicator	3.0	3.3	3.2	2.8	2.9
Numerator	5726	6213	6025	5451	5751
Denominator	190874	188270	188270	194681	198309
Data Source					BRFSS
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.7	2.7	2.6	2.6	2.6

Notes - 2008
2008 South Dakota BRFSS survey weighted data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 BRFSS survey weighted data. Rate based on 2006 South Dakota population estimate.

Notes - 2006
2006 BRFSS survey unweighted data. Rate based on 2005 South Dakota population estimate.

The percentages of children under age 18 without health insurance appears to fluctuate over the years while the trend indicates the rates are declining for the years 2002-2006. The 95 percent confidence intervals reveal that we should not consider any of the yearly changes significantly different from another because of the natural variations in the events. The five-year average percent of uninsured children is 3.5 percent. The percentages range from a low of 3.0 to a high of 4.1.

a. Last Year's Accomplishments
• Collaborated with DSS to assure information regarding SCHIP and the expanded non-Medicaid SCHIP program was distributed to DOH staff and communities. Communication occurs at numerous levels including upper management.
• Provided SCHIP applications to OCHS/PHA offices and assisted in completion of forms as needed.
• Provided links to DSS Medicaid website from the DOH website.
• Required all clients requesting financial assistance with CSHS to first apply for Title XIX.
• Provided information regarding the South Dakota Risk Pool to families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Assure information regarding SCHIP is distributed to DOH staff and communities.				X
2. Provide SCHIP applications in DOH field offices and assist with completion of forms as needed.			X	
3. Provide links to DSS Medicaid website from DOH website.				X
4. Assure information regarding the South Dakota Risk Pool is available.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Collaborating with DSS to assure information regarding SCHIP and the expanded non-Medicaid SCHIP program is distributed to DOH staff and communities.
• Assuring families accessing DOH programs are provided information on available programs (i.e., SCHIP, Medicaid and Risk Pool).

c. Plan for the Coming Year

• Provide financial assistance under CSHS to families up to 250% of FPL with no cost share.
• Require all clients requesting financial assistance with CSHS to first apply for Title XIX.
• Provide information on the South Dakota Risk Pool to individuals who have lost their insurance coverage through no fault of their own and are unable to access different coverage.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			32	31	34
Annual Indicator		32.0	32.2	34.6	35.9
Numerator		2754	2649	2993	3276
Denominator		8605	8228	8651	9125
Data Source					PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	35	34	33	32

Notes - 2008
2008 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data. As annual indicator continues to rise, the annual performance objectives for 2009-2013 were modified. The 2009 objective is expected to increase as new corrective measures will not be in place until later in the year.

Notes - 2007
2007 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data

Notes - 2006
2006 South Dakota Pediatric Nutrition Surveillance System (PedNSS) data.

Overweight and at risk of overweight (Body Mass Index (BMI) at or above the 85th percentile) remained constant for the first time since the state started collecting this data. The 32% is above the national average of 30.9% for CY04; however the South Dakota overweight percent of 13.9% is below the national rate of 14.8% (2004) for WIC participants and the same as the current NHANES percent for all 2-5 year olds.

a. Last Year's Accomplishments

• Collaborated with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases especially those objectives and strategies focused on parents and caregivers.
• Developed and piloted the Fit from the Start initiative in registered childcare facilities and to modify the Growing Healthy childcare curriculum for providers and parents.
• Provided educational information and materials to DOH staff and others for use with parents and childcare providers on how to increase physical activity for all ages of children including strategies to decrease TV viewing.
• Collaborated with partners to educate parents and childcare providers on the importance of good nutrition and physical activity for children.
• Utilized healthysd.gov and DOH websites to provide updated consumer and provider resources for overweight children and adolescents.
• Co-sponsored South Dakota State University (SDSU) Nutrition Seminar on nutrition through the lifecycle and sponsored the UAB satellite conference to 10 sites on pediatric obesity treatment.
• Collaborated with GFP to offer physical activity and nutrition programming for families visiting state parks through recreation equipment, materials, and programs.
• Provided "Fruits and Veggies -- More Matters" materials for parents to increase fruit and vegetable intake.
• Promoted National Turn of the TV Week in collaboration with program partners and healthysd.gov.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Partner to provide nutrition and physical activity expertise.				X
2. Collaborate with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases.				X
3. Provide media messages regarding healthy strategies to prevent obesity in preschool children.			X	
4. Implement Fit From the Start Initiative in childcare facilities to increase access to vegetables, improve opportunities for physical activity, and decrease tv viewing for children 2-5 years of age.				X
5. Provide educational information and materials to DOH staff and others to use with parents and childcare providers on how to increase physical activity for all ages of children including strategies to decrease tv viewing.			X	
6. Collaborate with partners to educate parents and childcare providers on the importance of good nutrition and physical activity for children.			X	
7. Promote South Dakota Great Day of Play.			X	
8. Utilize healthysd.gov and DOH websites to provide updated consumer and providers resources for overweight children and adolescents.			X	
9. Co-sponsor SDSU Nutrition seminar.			X	
10. Provide "Fruits and Veggies -- More Matters" materials for parents to increase fruit and vegetable intake.			X	

b. Current Activities
• Providing nutrition and physical activity expertise to programs impacting preschool children.
• Collaborating with partners to implement objectives and activities in the State Plan to Prevent Obesity and Other Chronic Diseases focused on parents and caregivers.
• Providing media messages regarding healthy strategies to prevent obesity.

• Implementing Fit from the Start Initiative in childcare facilities to increase access to vegetables, improve opportunities for physical activity, and decrease tv viewing for children 2-5 years of age; trained 35 childcare specialists to provide local training to providers and implement initiative; trainers are from Early Childhood Enrichment Centers, SDSU Cooperative Extension, and DOE food program sponsors.
• Providing information/materials to DOH staff and others on the importance of good nutrition and increasing physical activity for all ages of children including strategies to decrease tv viewing.
• Planning for third "South Dakota Great Day of Play" in collaboration with the SD Park and Recreation Association to urge children, adults, and families to get outside and play or be physically active.
• Utilizing healthysd.gov and DOH websites to provide updated consumer and provider resources for overweight children and adolescents.
• Sponsoring seminar on use of technology in nutrition.
• Providing materials for parents on "Fruits & Veggies -- More Matters".

c. Plan for the Coming Year
• Provide educational information and materials to DOH staff and interested parties for use with parents and others who serve preschool children on how to increase physical activity and healthy eating, especially fruits and vegetables, for all ages of children.
• Implement current State Plan to Prevent Obesity and Other Chronic Diseases.
• Work with partners to educate parents on the importance of good nutrition and physical activity for their children.
• Utilize DOH and healthysd.gov websites to provided updated consumer and provider resources for overweight children and adolescents.
• Collaborate with GFP to offer physical activity and nutrition programming for families visiting state parks through recreation equipment, materials, and programs.
• Collaborate with SD Park and Recreation Association and GFP to conduct "South Dakota Great Day of Play".
• Promote National Turn Off the TV Week to include activities targeting the pre-school population.
• Implement Fit from the Start Initiative and assist in planning and conducting evaluation of initiative successes to increase access to vegetables, improve opportunities for physical activity, and decrease tv viewing for children 2-5 year of age in childcare facilities.
• Implement new food package to include fresh fruits and vegetables, whole grains, reduction in juice allowed, eggs, and milk; WIC will only allow low fat milk for children 2-5 years of age. WIC will distribute "Get Healthy Now" kit to all 2-5 year old participants which was developed by the National WIC Association in conjunction with Sesame Street that addresses nutrition. The kit includes a storybook, caregiver guide, and dvd and is based on Sesame Workshop's Healthy Habits for Life Initiative.
• Collaborate with partners to explore better ways to educate parents about nutrition and physical activity.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			10	14	14
Annual Indicator			14.0	14.2	13.0
Numerator			1645	1707	1545
Denominator			11722	12061	11859
Data Source					Birth

					Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	13	13	13	13

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data. The percentage of women who smoke in the last three months of pregnancy shows a slight increase over 2006 but no difference statistically. Due to the fact that only two years of data are available, no trend can be determined at this time.

Notes - 2006
2006 South Dakota birth certificate data.
Annual performance measure should be 14.

a. Last Year's Accomplishments
• Collaborated with March of Dimes, Perinatal Association, American Cancer Society, and CHAD to educate professionals about the risks associated with smoking during pregnancy.
• Risk assessed pregnant clients and provide tobacco cessation/referral services to clients.
• Provided education materials and referral information to pregnant clients and their families.
• Facilitated completion of Tribal PRAMS for OCHS clients who had not responded to the survey.
• Contracted with Healthy Start to expand direct services on Rosebud and Pine Ridge reservations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Risk assess all pregnant women seeking services within OCHS/PHA offices for smoking status three months prior to pregnancy as well as current smoking status.			X	
2. Provide education, informational materials, and referrals to encourage and assist with smoking cessation.		X		
3. Collaborate with a variety of organizations to educate professionals about the risks associated with smoking during pregnancy.				X
4. Contract with Northern Plains Healthy Start to expand staff on Rosebud and Pine Ridge Reservations.				X
5. Collaborate with Healthy Start to collect data on smoking and the correlation between smoking and premature birth and low birth weight infants born to clients they serve.				X
6. Monitor and compare data collected from the Perinatal Health Risk Assessment and PRAMS surveys which assess among other things tobacco use before, during, and after pregnancy.				X
7. Collaborate with DSS to include tobacco prevention messages			X	

and incentives in the Bright Start Welcome Boxes.				
8.				
9.				
10.				

b. Current Activities

• Risk assessing pregnant clients and providing tobacco cessation/referral services to clients.
• Promoting South Dakota QuitLine to assist pregnant women quit using tobacco.
• Provide training to professionals about the risks associated with smoking during pregnancy.
• Contracting with Northern Plains Healthy Start to expand direct services on Rosebud and Pine Ridge Reservations.
• Utilizing data obtained from the revised birth record, 2009 Perinatal Health Risk Assessment Survey and PRAMS to assess tobacco use before, during, and after pregnancy and potential disparities between Native American and non-Native American populations.
• Providing tobacco prevention materials in Bright Start Welcome Boxes to reinforce the message of not smoking during future pregnancies and preventing secondhand smoke exposure for infants and young children.

c. Plan for the Coming Year

• Promote South Dakota QuitLine for pregnant women.
• Provide tobacco prevention education materials and technical assistance to health care providers as requested.
• Collaborate with March of Dimes, Perinatal Association, American Cancer Society, and CHAD to educate professionals about the risks associated with smoking during pregnancy.
• Risk assess pregnant clients and provide tobacco cessation/referral services to clients.
• Contract with Northern Plains Healthy Start to provide direct service staff on reservations.
• Continue meeting with Healthy Start staff to build relationships, obtain data, and provide tobacco prevention materials/technical support.
• Conduct statewide public education/media campaign targeting pregnant women.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	14	17.5	17	17	22
Annual Indicator	19.7	21.7	23.5	22.2	24.2
Numerator	12	13	14	13	14
Denominator	60766	59965	59469	58689	57734
Data Source					Death Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**

Annual Performance Objective	22	21.8	21.8	21.6	21.4

Notes - 2008
2006-2008 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rate is based on 2006-2008 South Dakota population estimates.

Notes - 2007
2005-2007 South Dakota death certificate data. Numerators and denominators are 3-year averages. Rate based on 2004-2006 South Dakota population estimates.

Notes - 2006
2004-2006 South Dakota death certificate data. Numerators and denominators are 3-year averages. Rate based on 2003-2005 South Dakota population estimates.

South Dakota continues to experience high rates of suicide -- particularly among the American Indian population and in rural areas of the state. Factors which may impact rates include poverty and lack of employment opportunities on the reservation and the drought conditions in the state which puts a strain on farm families.

The small numbers tend to produce rates with more variability than larger numbers due to chance variations. No adjustments will be made in the Annual Performance Objective until a definite trend can be identified.

a. Last Year's Accomplishments
• Partnered with DHS to fund the Front Porch Coalition and HELP!Line Center to: (1) provide training and consultation for the implementation of the Substance Abuse and Mental Health Services Administration (SAMHSA) Garrett Lee Smith (GLS) Youth Suicide Prevention Grant in South Dakota; (2) answer crisis line phone calls from across the state at the HELP!Line Center through the National Suicide Prevention Lifeline (1-800-273-TALK and 1-800-SUICIDE) to provide crisis assistance; (3) represent South Dakota at the American Association of Suicidology conference and the Suicide Prevention Action Network SPAN USA Legislative Institute; (4) deliver presentations on postvention for suicide grief and suicide gatekeeper training at SAMSHA's technical assistance meeting for GLS grantees; (5) present to crisis centers on the new suicide risk assessment instrument developed at the HELP!Line Center; (6) present on the South Dakota Strategy for Suicide Prevention (SDSSP) at the South Dakota Public Health Conference and Mental Wellness Conference; (7) provide training for facilitators of suicide survivor support groups; (8) add National Center for Suicide Prevention Training's youth gatekeeper online training program to the SDSSP website; (9) work with Rosebud Indian Reservation to address suicide deaths and attempts; and (10) refine and update the SDSSP website.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Sponsor attendance at American Association of Suicidology conference.				X
2. Present to crisis centers on the new suicide risk assessment instrument developed at the HELP! Line Center.			X	
3. Provide consultation and support for SAMSHA grant activities.				X
4. Provide training for facilitators of suicide survivor support groups.		X		
5. Provide consultation and support to the Garrett Lee Smith grant activities.				X

6. Work with the Rosebud Indian Reservation to address the number of suicide deaths and attempts.			X	
7. Refinine and update suicide prevention website.				X
8.				
9.				
10.				

b. Current Activities

• Partnering with DHS to fund the Front Porch Coalition and HELP!Line Center to: (1) provide consultation and support to Suicide Awareness Partnership activities including distributing promotional materials for the National Suicide Prevention Lifeline phone number as well as providing additional ASIST trainings for caregivers in suicide intervention; and (2) answer crisis line phone calls from across the state at the HELP!Line Centers through the National Suicide Prevention Lifeline to provide crisis assistance.

c. Plan for the Coming Year

• Partner with DHS to fund the Front Porch Coalition and HELP!Line Center to: (1) provide suicide prevention curriculum to secondary students; (2) improve suicide prevention policies and practices in schools; (3) provide communities with gatekeeper training, suicide intervention training, and clinical training for suicide assessment and treatment; (4) distribute suicide prevention information/materials to community caregivers and agencies; (5) augment the work of community-level suicide prevention task forces and initiative activities including support for resiliency curriculum in secondary schools, support for the development of programs for people grieving after a loss to suicide, providing Mental Health First Aid training, and reorganizing the SDSSP by bringing in community task force leaders; and (6) expand awareness of the SDSSP website and training community task force leaders to use the website to coordinate and share activities.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	90	89	90	87
Annual Indicator	89.1	87.8	87.4	86.6	86.4
Numerator	123	108	111	97	114
Denominator	138	123	127	112	132
Data Source					Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87	87	87.5	87.5	87.5

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data. The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates shows a slight downward trend. While the rates tend to decline over the years, there are no significant differences between the years statistically.

Notes - 2006
2006 South Dakota birth certificate data.
Annual performance measure should be 90.

a. Last Year's Accomplishments
• Collaborated with DSVR to monitor the number of very low birth weight infants born at locations other than facilities with Level III nurseries.
• Collaborated with physician, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants, including preterm labor.
• Participated on March of Dimes Coalition to address issues related to prematurity.
• Assessed all pregnant women seen at OCHS/PHA sites for risks that have the potential to affect pregnancy outcomes and provided ongoing education to clients on the signs of preterm labor.
• Provided current pregnancy information and strategies for reducing the risk of preterm birth on the DOH website.
• Contracted with Northern Plains Healthy Start to expand direct service on the Rosebud and Pine Ridge Reservations.
• Facilitated completion of Tribal PRAMS for OCHS clients who had not responded to the survey.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participate in March of Dimes Coalition to address issues related to prematurity.				X
2. Assess/educate women seen at OCHS/PHA sites for risk factors affecting pregnancy outcomes.			X	
3. Educate women on Baby Care/Bright Start programs on signs of preterm labor.			X	
4. Contract with Northern Plains Healthy Start to expand direct service on Rosebud and Pine Ridge reservations.	X			
5. Obtain data on access to prenatal care and correlation of smoking to premature/low birth weight infants through Healthy Start contract.				X
6. Compare data obtained from PRAMS and 2009 Perinatal Health Risk Assessment to identify disparities in risk reduction behaviors between Native American and non-Native American populations.				X
7. Collaborate with March of Dimes and Perinatal Association to educate health professionals about risk factors associated with prematurity and low birth weight.				X
8.				
9.				
10.				

b. Current Activities

• Collaborating with DSVR to monitor the number of very low birth weight infants born at locations other than facilities with Level III nurseries.
• Collaborating with physician, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants, including preterm labor.
• Participating on March of Dimes Coalition to address issues related to prematurity.
• Assessing all pregnant women seen at OCHS/PHA sites for risks that have the potential to affect pregnancy outcomes and providing ongoing education to clients on the signs of preterm labor.
• Collaborating with IHS to monitor prevalence of low birth weight infants among the Native American population via PRAMS and Healthy Start projects.

c. Plan for the Coming Year
• Collaborate with DSVR to monitor the number of very low birth weight infants born at locations other than facilities with Level III nurseries.
• Collaborate with physician, hospital systems, March of Dimes, Perinatal Association, and other MCH partners to identify issues surrounding delivery of very low birth weight infants, including preterm labor.
• Participate on March of Dimes Coalition to address issues related to prematurity.
• Assess all pregnant women seen at OCHS/PHA sites for risks that have the potential to affect pregnancy outcomes and provide ongoing education to clients on the signs of preterm labor.
• Collaborate with Northern Plains Healthy Start to collect data and address disparities.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	86	78	80	80	69.8
Annual Indicator	77.6	79.2	68.5	69.7	67.7
Numerator	8801	9086	8160	8544	8179
Denominator	11339	11466	11914	12253	12074
Data Source					Birth Certificate
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69.8	70	70	70.3	70.3

Notes - 2008
2008 South Dakota birth certificate data. Trimester of prenatal care for 2008 was determined using date last normal menses began and date of first prenatal care visit. Data prior to 2006 used the month prenatal care began provided on the birth certificate.

Notes - 2007

2007 South Dakota birth certificate data. The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester shows a downward trend. While the rates indicate a downward trend, caution should be used in interpreting the data due to a change in the way this data are collected. The trimester of prenatal care data for 2006 and later are determined using date last normal menses began and date of first prenatal care visit while data prior to 2006 used the months prenatal care began provided on the birth certificate.

Notes - 2006
2006 South Dakota birth certificate data. Trimester of prenatal care for 2006 data was determined using date last normal menses began and date of first prenatal care visit; prior data used the month prenatal care began that was provided on the birth certificate.

The drop in the annual indicator is reflective of the way in which data is collected. The birth certificate no longer asks when prenatal care is initiated and instead uses the first day of the last normal menstrual period to make that determination. Increasing the percent of women seeking prenatal care in the first trimester continues to be a challenge in South Dakota. The Department of Health recently implemented the "I Didn't Know" media campaign aimed at increasing awareness of the importance of early prenatal care and recognizing the signs of pregnancy.

The small numbers tend to produce rates with more variability than larger numbers due to chance variations. No adjustments will be made in the Annual Performance Objective until a definite trend can be identified.

a. Last Year's Accomplishments
• Encouraged pregnant clients seen at OCHS/PHA and delegate family planning sites to access early and regular prenatal care.
• Facilitated access to early prenatal care for pregnant women enrolled in Bright Start, Baby Care, and WIC.
• Collaborated with March of Dimes, Perinatal Association, and IHS to disseminate "I Didn't Know" materials to increase awareness of pregnancy symptoms and the importance of early prenatal care.
• Provided pregnancy test kits to Healthy Start sites to facilitate access to pregnancy testing and early referral to prenatal services.
• Facilitated completion of Tribal PRAMS for OCHS clients who had not responded to the survey.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Encourage pregnant clients seen at OCHS/PHA and delegate family planning sites to access early and regular prenatal care.			X	
2. Partner with Medicaid to provide risk assessments and case management services to pregnant women to improve pregnancy outcomes.				X
3. Monitor data obtained from PRAMS and 2009 Perinatal Health Risk Assessment to identify barriers to obtaining early prenatal care as well as racial disparities.				X
4. Contract with Northern Plains Healthy Start to provide direct services to reservations.				X
5. Provide pregnancy test kits to Healthy Start sites.				X
6.				
7.				
8.				
9.				

10.				

b. Current Activities

• Encouraging pregnant clients seen at OCHS/PHA and delegate family planning sites to access early and regular prenatal care.
• Partnering with Medicaid to provide risk assessments and case management services to pregnant women to improve pregnancy outcomes.
• Facilitating access to early prenatal care for pregnant women enrolled in Bright Start, Baby Care, and WIC.
• Compiling data from the 2009 Perinatal Health Risk Assessment Survey of new mothers which collects information on barriers to obtaining early and regular prenatal care.
• Identifying barriers to early prenatal care as well as disparities between Native American and non-Native American populations.
• Collecting data from IHS for clients utilizing Healthy Start for pregnancy testing.

c. Plan for the Coming Year

• Encourage pregnant clients seen at OCHS/PHA and delegate family planning sites to access early and regular prenatal care.
• Facilitate access to early prenatal care for pregnant women enrolled in Bright Start, Baby Care, and WIC.
• Provide pregnancy test kits to Healthy Start sites and South Dakota reservations to facilitate access to pregnancy testing and early referral to prenatal services.
• Collaborate with Healthy Start to collect ongoing data and address racial disparities in accessing early prenatal care.
• Increase public awareness of signs and symptoms of pregnancy and importance of early prenatal care.
• Disseminate the report of 2009 Perinatal Health Risk Assessment Survey of new mothers.

D. State Performance Measures

State Performance Measure 2: *The rate (per 1,000 live births)of infants under age one who die as a result of Sudden Infant Death Syndrome.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	1.3	1.2	1.2	1.1	0.8
Annual Indicator	1.1	0.9	0.8	0.8	0.9
Numerator	12	10	9	9	11
Denominator	11020	11276	11573	11878	12080
Data Source					Birth and death certificate
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0.8	0.7	0.7	0.7	0.7

Notes - 2008

2006-2008 South Dakota birth and death certificate data - 3 year averages

Notes - 2007

2005-2007 South Dakota death certificate data – 3-year averages. The rate of infants (per 1,000 live births) under age one who die as a result of SIDS shows a downward trend. While the rates trend downward, none of the rates are significantly different than the other due to the small numbers. Three-year averages were used to stabilize the rates somewhat but the small numbers still result in large confidence intervals making significant differences unlikely.

Notes - 2006
2004-2006 South Dakota death certificate data - 3 year average

a. Last Year's Accomplishments
• Promoted the "Back to Sleep" campaign to educate parents and other caregivers on how to reduce SIDS deaths and the importance of laying babies on their backs to sleep.
• Collaborated with DSS to include SIDS and "Back to Sleep" materials in the Bright Start Welcome Boxes.
• Collaborated with Bright Start home visit nurses, Healthy Start contacts, local health councils, DOH staff, Head Start, and registered/licensed day care providers to promote "Back to Sleep" campaign with new parents.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote Back to Sleep campaign through Bright Start, Healthy Start, day cares, etc.			X	
2. Include Back to Sleep materials in Bright Start Welcome Boxes.				X
3. Monitor and compare infant sleep position data collected through Perinatal Health Risk Assessment Survey and Tribal PRAMS.				X
4. Utilize web-based resources to receive and disseminate current information specific to SIDS.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Promoting the "Back to Sleep" campaign to educate parents and other caregivers on how to reduce SIDS deaths and the importance of laying babies on their backs to sleep.
• Collaborating with DSS to include SIDS and "Back to Sleep" materials in the Bright Start Welcome Boxes.
• Collaborating with Bright Start home visit nurses, Healthy Start contacts, local health councils, DOH staff, Head Start, and registered/licensed day care providers to promote "Back to Sleep" campaign with new parents.
• Monitoring and comparing Tribal PRAMS and Perinatal Health Risk Assessment data to determine if there is a difference in SIDS reducing behaviors between Native American and non-Native American populations.
• Participating in Project Impact listserv and trainings to stay current on SIDS information.

c. Plan for the Coming Year

• Promote the "Back to Sleep" campaign to educate parents and other caregivers on how to reduce SIDS deaths and the importance of laying babies on their backs to sleep.
• Collaborate with DSS to include SIDS and "Back to Sleep" materials in the Bright Start Welcome Boxes.
• Collaborate with Bright Start home visit nurses, Healthy Start contacts, local health councils, DOH staff, Head Start, and registered/licensed day care providers to promote "Back to Sleep" campaign with new parents.
• Utilize appropriate resources to stay current on SIDS information.
• Collaborate with Healthy Start representatives to address disparities in the incidence of SIDS in the Native American population.

State Performance Measure 3: *Percent of pregnancies which are unintended (mistimed or unwanted) and result in live birth or abortion.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	38	38	38	38	33.4
Annual Indicator	41.3	37.4	37.2	33.4	33.9
Numerator	4881	4466	4591	4229	4256
Denominator	11813	11949	12356	12670	12568
Data Source					Birth certificate
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	33.2	33.2	33	33	33

Notes - 2008
Prorated 2008 South Dakota birth certificate data based on 2007 Perinatal Health Risk Assessment Survey data and 2008 South Dakota abortion data

Notes - 2007
Prorated 2007 South Dakota birth certificate data based on the 2007 Perinatal Health Risk Assessment Survey data and 2007 South Dakota abortion data.

Notes - 2006
Prorated 2006 South Dakota birth certificate data based on the 2005 Perinatal Health Risk Assessment Survey data and 2006 South Dakota abortion data.

a. Last Year's Accomplishments
• Provided family planning services to 11,611 clients in CY08. Of these clients, 8,366 were women over the age of 19 and 3,043 were adolescents aged 19 and under. Of the total clients, 8,476 were at or below 150 percent of poverty and 11,063 women accessed a method of birth control.
• Prevented 8,075 pregnancies during CY08 (as determined by utilizing James Trussell's methodology for calculating pregnancies prevented).
• Provided community education regarding reproductive health/family planning to 793 adults during CY08.
• Received additional Title X directed supplemental funding to provide cost effective and efficacious contraceptives, increase the number of clients receiving services, and provide rapid HIV testing during the family planning visit.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services to women at risk of unintended pregenancy.			X	
2. Provide community education to individuals/groups regarding reproductive health and family education.			X	
3. Seek additional funding to provide cost effective/efficacious contraceptives and community efforts/partnerships.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Providing counseling, education, medical, and contraceptive services to women at risk of unintended pregnancy.
• Providing community education to individuals and groups regarding reproductive health/family planning topics.
• Seeking additional funding through Title X directed supplemental funds to provide cost effective and efficacious contraceptives.

c. Plan for the Coming Year

• Provide family planning services to populations at high risk for unintended pregnancy.
• Provide community education to individuals and groups regarding reproductive health and family planning topics.
• Collaborate on abstinence-only grant activities.

State Performance Measure 4: *Percent of high school youth who self-report tobacco use in the past 30 days.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	30	30	28	28	24.7
Annual Indicator	30.0	28.0	28.0	24.7	24.7
Numerator	13528	12315	12315	10757	10757
Denominator	45095	43981	43981	43550	43550
Data Source					YRBS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	24.5	24.5	24.4	24.4	24.3

Notes - 2008
2006/2007 South Dakota school enrollment based on 2007 Youth Risk Behavior Survey data

Notes - 2007
2006-2007 South Dakota school enrollment based on 2007 Youth Risk Behavior Survey data. The 2007 YRBS shows a decrease in the percent of high school youth who are current smokers.

In 2007, 11% report spit tobacco use which was down from 13% in the 2005 survey. The Tobacco Control Program collaborates with the Department of Education to collect tobacco usage data through the YRBS. South Dakota repeats the survey every two year.

Notes - 2006
2004/2005 South Dakota school enrollment based on 2005 Youth Risk Behavior Survey data.

The latest YRBS reports 28% of high school youth are current smokers -- down from 30% in the 2003 report. In 2005, 13% report spit tobacco use which is down from 15% in 2003. The TCP collaborates with DOE to collect tobacco usage data through YRBS and the survey is repeated every two years. The survey was administered to students in the spring of 2007. Updated data will be available in the next application.

a. Last Year's Accomplishments
• Served on DHS Alcohol and Drug Abuse Council.
• Provided QuitLine materials to OCHS staff to facilitate efforts to inform parents and the community about the health effects of smoking, secondhand smoke and spit tobacco.
• Collaborated with other state agencies to administer the YRBS in South Dakota high schools.
• Provided QuitLine referral materials to DOH field offices, medical providers, tribal health, and other partners.
• Utilized Prevention Resource Centers (PRCs) to distribute educational materials regarding tobacco use.
• Conducted public education campaign targeting youth and focusing on the effects of tobacco use and secondhand smoke.
• Encouraged/supported participation of schools and youth in local tobacco prevention coalitions.
• Provided statewide cessation services via the QuitLine at no cost to the caller.
• Partnered with DOE to support and incorporate tobacco prevention education in schools.
• Partnered with DHS to support and incorporate tobacco prevention in several South Dakota communities.
• Offered tobacco prevention grants to all South Dakota K-12 public, private, and tribal school districts with an enrollment of 100 students or more; provided $548,000 to 85 school districts through grants.
• Provided resources for the Bright Start Welcome Box about the dangers of exposing newborns and children to secondhand smoke.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Sponsor community coalitions working on tobacco prevention at the local level.				X
2. Implement tobacco prevention education model in schools.			X	
3. Conduct countermarketing campaigns at state and local level.			X	
4. Provide OuitLine at no cost to the caller.			X	
5. Utilize data from YRBS and Youth Tobacco Survey to refine program activities to address specific populations with higher tobacco use including high school and middle school students.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Partnered with the Minnesota Institute of Public Health to develop and disseminate a tobacco prevention tool kit to all South Dakota K-12 school districts. Copies of the tool kit were delivered to all grantee schools and was also made available on the TCP website for downloading by non-grantee schools.
• Partnering with the Minnesota Institute of Public Health to develop and disseminate a tobacco prevention tool kit to all South Dakota post-secondary schools.
• Providing cessation services via the QuitLine at no cost to the caller.
• Collaborating with DOE to sponsor implementation of tobacco prevention education (LifeSkills) in South Dakota schools.
• Providing technical assistance and resources to DOH staff, community groups, schools, parents, health care providers, and others working on tobacco prevention.
• Conducting countermarketing/public education campaigns targeting youth.
• Providing Teens Against Tobacco Use (TATU) training to various groups of students around the state.
• Providing audiovisual messages to OCHS and DSS Medicaid offices to deliver tobacco prevention and cessation messaging to clients.
• Providing funding support for a web-based tobacco prevention program to be offered at no cost to all K-12 schools in South Dakota.

c. Plan for the Coming Year
• Provide cessation services via the QuitLine at no cost to the caller.
• Distribute grant funds to K-12 schools and post-secondary institutions to decrease tobacco use among children and young adults.
• Collaborate with DOE to conduct the YRBS.
• Collaborate with DOE to support LifeSkills training and curriculum for schools.
• Provide TATU training to students.
• Provide tobacco prevention education materials and resources to youth organizations through community coalitions.
• Provide technical assistance and resources to DOH staff, community groups, schools, parents, health care providers, and others working on tobacco prevention.
• Conduct countermarketing/public education campaigns targeting youth.
• Provide tobacco prevention messages in South Dakota High School Activities Association event programs.

State Performance Measure 5: *Percent of school-aged children and adolescents with a Body Mass Index (BMI) at or above the 95th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	17.5	16.2	16	15.8	16.2
Annual Indicator	15.8	16.4	16.9	16.3	16.3
Numerator	4305	5820	7647	6777	6036
Denominator	27245	35489	45251	41579	37028
Data Source					SD School Height-Weight
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16	15.8	15.6	15.4	15.3

Notes - 2008

2007/2008 South Dakota school year School Height and Weight data. The rate of K-12 students who are at or above the 95th percentile BMI-for-age was 16.3% for 2006-2007 and 2007-2008 school years. NHANES IV results for 2003-2004 indicate that 18.8% of children ages 6-11 are above the 95th percentile and 17.4% of adolescents ages 12-19 are in this obese category.

Notes - 2007
2006/2007 South Dakota school year School Height and Weight data

Notes - 2006
2005/2006 South Dakota school year School Height and Weight data

a. Last Year's Accomplishments
• Collected and analyzed school height and weight data for the 2007-08 school year.
• Received data from 241 schools on 41,579 students for the 2006-07 school year; data collected showed 16.3% of South Dakota students were obese (BMI for age 95th percentile and above) and 32.9% are overweight or obese. The obese rate of 16.3% was down from 16.9%.
• Provided 32 balance beam scales and measuring boards to schools to improve school height-weight data quality and assist schools who wish to participate in the project but can't due to lack of equipment.
• Collaborated with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases especially those objectives and strategies focused on parents, caregivers, schools, and youth organizations.
• Provided print materials on child obesity to schools and others who serve youth and made materials available on the DOH website.
• Coordinated with DOE to support and/or assist schools with selection and implementation of comprehensive health education.
• Collaborated with DOE to develop and sponsor the South Dakota Schools Walk program which promotes walking in schools as a way to increase physical activity among youth and help combat obesity. All elementary teachers were invited to register their classes online and receive free incentives for their students. For the 2006-07 school year, 267 classrooms representing approximately 10,000 K-12 students and 667 staff participated.
• Awarded 17 grants to schools, out-of-school programs, and groups serving youth to support activities to improve policy and environment through physical activity and nutrition.
• Co-sponsored SDSU Nutrition Seminar on nutrition through the lifecycle with focus on obesity prevention and sponsored pediatric update satellite conference to ten sites across the state.
• Promoted a Clinical Obesity Toolkit for healthcare providers.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collect, analyze, and interpret school height/weight data and distribute to health/education providers and promote computerized data collection system.				X
2. Provide balance beam scales and measuring boards to schools to improve school height-weight data.				X
3. Provide resources to increase physical activity for children/adolescents including strategies to decrease tv viewing, promoting Turn Off the TV Week, and South Dakota Great Day of Play.			X	
4. Collaborate with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Diseases.				X
5. Provide print materials on child obesity to schools and others who serve youth and make materials available on the DOH website.			X	

6. Collaborate with DOE to promote South Dakota Schools Walk to schools and out-of-school time programs.				X
7. Sponsor seminars on pediatric obesity-related topics.			X	
8.				
9.				
10.				

b. Current Activities

• Collecting/analyzing school height-weight data for 2008-09 school year; provided data from 2007-2008 school year back to the participating 249 schools representing 37,028 students.
• Providing 26 balance beam scales/measuring boards to schools to improve school height-weight data collection.
• Providing resources to increase physical activity for children/adolescents including strategies to decrease tv viewing, promoting "Turn Off the TV Week" and the "South Dakota Great Day of Play", and providing Healthy South Dakota posters to schools.
• Collaborating with partners to implement strategies in the State Plan to Prevent Obesity and Other Chronic Disease.
• Promoting South Dakota Schools Walk program in collaboration with CSHP to K-6 grade schools and out-of-school time programs; implementing mileage club.
• Using the CSHP electronic newsletter "NewsInfused" to share information with public, private, tribal, and BIA schools in the state.
• Sponsoring a seminar or education session on pediatric obesity.

c. Plan for the Coming Year

• Provide nutrition and physical activity expertise.
• Collect, analyze, and interpret available height-weight data for school-aged children and distribute information to appropriate health and education providers in an effort to reduce the percent of overweight children.
• Encourage schools to use computerized data collection system to submit height-weight data.
• Provide education information and materials to DOH staff and others for use with parents and schools on how to increase physical activity and healthy eating for all ages of children.
• Utilize healthysd.gov website to provide updated consumer and provider resources on overweight children and adolescents.
• Collaborate with South Dakota Park and Recreation Association, GFP and other interested agencies to promote "South Dakota Great Day of Play".
• Promote National Turn off the TV Week in collaboration with program partners.
• Implement current State Plan to Prevent Obesity and Other Chronic Diseases objectives and activities to address obesity in schools; assist in drafting new plan for the next five years.
• Contract with Educational Service Agency to manage a pilot project for educators on effective health and physical education curriculum, instruction, and assessment through the development of a regional-based training plan.

State Performance Measure 8: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			70	70	73.9
Annual Indicator	68.7	69.7	72.5	73.9	74.8
Numerator	8090	8313	8962	9454	9425

Denominator	11773	11928	12356	12792	12593
Data Source					SD Metabolic Screening Program
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	74	74	74.1	74.1	74.1

Notes - 2008
2008 South Dakota Metabolic Screening Program data

Notes - 2007
2007 South Dakota Metabolic Screening Program data.

The percentages of mothers who breastfeed their infants at hospital discharge shows an upward trend. The last two years of data shows a significant difference over the other years with the 2007 data also being significantly different from the 2006 data.

Notes - 2006
2006 South Dakota Metabolic Screening Program data

Annual Indicator has increased to a 72.5, which has met our objective of 72. This current year hospitals were analyzing their initiation rates with previous years rates and trying to find a plan to increase for the coming year.

a. Last Year's Accomplishments
• Collected breastfeeding initiation rates for the state and by individual hospital via the Newborn Screening Program. Sent letters to hospitals with their individual rates and materials on how to increase and support breastfeeding.
• Loaned 320 electric breast pumps to MCH and WIC clientele to encourage continued breastfeeding. WIC also provided program participants with manual breast pumps as needed.
• Participated on the SD Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion. Collaborated with the coalition to promote World Breastfeeding Week and obtained a Governor's proclamation for World Breastfeeding Week.
• Provided education and support to mothers in the Bright Start home visiting program, WIC, and Baby Care programs to encourage continued breastfeeding.
• Worked with the breastfeeding coordinator from local OCHS offices to promote breastfeeding and use of a breastfeeding class.
• Highlighted breastfeeding on the healthysd.gov website and two new brochures on returning to work and breastfeeding.
• Implemented a Breastfeeding Peer Counselor Program to work with pregnant and breastfeeding WIC clients in Beadle, Butte, Davison, Shannon, and Charles Mix counties to provide education and support breastfeeding. Counselors were trained using the Loving Support Through Peer Counseling curriculum. All five local agencies have also received training on the Breastfeeding Peer Counselor program and how they can work as a team to educate and support breastfeeding WIC participants.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Collect breastfeeding initiation rates for the state and by individual hospitals.		X		
2. Provide electric breast pumps to MCH/WIC clients to encourage continued breastfeeding.		X		

3. Serve on the Breastfeeding Coalition.				X
4. Educate mothers in various DOH programs of the benefits of breastfeeding and provide support/encouragement to initiate and continue breastfeeding.			X	
5. Provide and update breastfeeding information on the DOH and healthysd.gov websites.			X	
6. Provide resources to prenatal/breastfeeding educators.				X
7. Contract with Breastfeeding Consultant to provide breastfeeding peer counselors to the WIC program.				X
8.				
9.				
10.				

b. Current Activities

• Serving on the SD Breastfeeding Coalition; promoting World Breastfeeding Week; obtain a Governor's proclamation for World Breastfeeding Week.
• Educating mothers in the Bright Start home visiting, WIC, and Baby Care programs on the benefits of breastfeeding and providing support and encouragement to initiate and continue breastfeeding.
• Enhancing partnerships with Medicaid and health professionals to encourage more women to breastfeed.
• Providing updated breastfeeding information on the DOH and healthysd.gov websites.
• Developing, purchasing, and distributing materials for World Breastfeeding Week and ongoing marketing of breastfeeding.
• Collecting breastfeeding initiation data via the electronic birth certificate and providing hospitals with breastfeeding initiation data specific to their facility as well as information on ways to improve breastfeeding rates for their facility.
• Providing resources to prenatal/ breastfeeding educators to improve breastfeeding rates and promote two brochures on returning to work and breastfeeding.
• Providing a Breastfeeding Peer Counselor program for WIC clients in Beadle, Butte, Davison, and Charles Mix counties.

c. Plan for the Coming Year

• Serve on the SD Breastfeeding Coalition to provide a networking system for breastfeeding education and promotion and promote World Breastfeeding Week.
• Educate mothers in the Bright Start home visiting, WIC, and Baby Care programs on the benefits of breastfeeding and provide support and encouragement to initiate and continue breastfeeding.
• Enhance partnerships with Medicaid and health professionals to encourage more women to breastfeed.
• Provide updated breastfeeding information on the DOH and healthysd.gov websites.
• Develop, purchase, and distribute materials for World Breastfeeding Week and for ongoing marketing of breastfeeding.
• Provide resources to prenatal/breastfeeding educators as well as develop and implement a statewide plan to improve breastfeeding rates.
• Provide Breastfeeding Peer Counselor Program to WIC clients in Beadle, Butte, Davison, Charles Mix, Minnehaha, and Pennington counties to provide education and support breastfeeding.
• Implement new WIC food package which includes more foods for breastfeeding mothers to promote breastfeeding initiation, exclusivity, and duration; new foods include more fish, fresh fruits and vegetables, and whole grain options.
• Focus on prenatal women within the WIC program to encourage and demonstrate benefits of breastfeeding to increase initiation, exclusivity, and duration rates.

• Set statewide and local agency goals to increase initiation and duration of breastfeeding through nutrition education and marketing plans, state plan goals and objectives, and the Statewide Nutrition Action Plan.

State Performance Measure 9: *Percent of singleton birth mothers who achieve a recommended weight gain during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			21	22	29.5
Annual Indicator	20	20.8	30.4	29.5	30.9
Numerator		195	3498	3505	3604
Denominator		936	11524	11876	11650
Data Source					Birth certificate
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29.7	29.7	30	30	30

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data. The percent of singleton birth mothers who achieve a recommended weight gain during pregnancy shows an upward trend. While the rates indicate an upward trend, caution should be used in interpreting this data due to a change in the way the data are collected. 2006 and newer data are taken from the birth certificate data while data prior to 2006 were collected with the South Dakota Perinatal Health Risk Assessment survey.

Notes - 2006
2006 South Dakota birth certificate data.
The annual performance objective for 2006 should be 30.

a. Last Year's Accomplishments
• Educated mothers in WIC and perinatal programs about appropriate weight gain during pregnancy.
• Provided training for professionals on appropriate weight gain issues.
• Provided pedometers and education about physical activity in pregnancy to Baby Care/Bright Start participants.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Educate mothers in WIC and perinatal programs about appropriate weight gain during pregnancy.			X	
2. Assist pregnant women identify behavior changes and community resources to assist them in achieving approprate weight gain during pregnancy.			X	
3. Provide training opportunities for WIC, Baby Care, and Bright Start staff on appropriate weight gain during pregnancy.				X
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

• Researching problem of excessive weight gain during pregnancy to better define the problem.
• Providing training for WIC, Bright Start, and Baby Care staff regarding appropriate weight gain during pregnancy.
• Revising and developing DOH materials related to appropriate weight gain during pregnancy.

c. Plan for the Coming Year

• Educate pregnant women in WIC and perinatal programs about appropriate weight gain during pregnancy.
• Educate professionals on appropriate weight gain during pregnancy and risks associated with less than or more than recommended prenatal weight gain.

State Performance Measure 10: *Percent of infants exposed to secondhand smoke.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			14.5	14.5	9.4
Annual Indicator		14.6	14.6	9.4	9.4
Numerator		137	137	84	84
Denominator		936	936	896	896
Data Source					SD Perinatal Health Risk Assessment
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9.4	9.3	9.3	9.2	9.2

Notes - 2008
2007 South Dakota Perinatal Health Risk Assessment Survey data

Notes - 2007
2007 South Dakota Perinatal Health Risk Assessment Survey data.

Notes - 2006
2005 South Dakota Perinatal Health Risk Assessment Survey data.

Survey is conducted every other year so no new data to submit or progress to report.

a. Last Year's Accomplishments

• Conducted secondhand smoke public education campaign.
• Provided tobacco prevention messaging in Bright Start Welcome Boxes.
• Risk assessed all mothers in the Baby Care and Bright Start Nurse Home Visiting programs for smoking behaviors three months prior to pregnancy as well as during pregnancy.

• Provided education, resources, and referrals to all moms who indicate either smoking behaviors or exposure to secondhand smoke within their environment.
• Explored smoking cessation or limiting/eliminating exposure to secondhand smoke strategies to assist those moms that have quit smoking to remain tobacco free.
• Provided cessation services via the QuitLine at no cost to the caller.
• Distributed Perinatal Health Risk Assessment Survey Report which has data pertaining to tobacco use and secondhand smoke exposure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Risk assess all mothers regarding smoking behaviors and exposure to secondhand smoke.			X	
2. Provide educational materials and resources to mothers regarding effects of tobacco use on them, their developing fetus, and their other children.			X	
3. Make referrals as needed for smoking cessation strategies as well as strategies to limit or eliminate exposure to secondhand smoke.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
• Working with DSS staff to include tobacco prevention messaging in Bright Start Welcome Boxes.
• Risk assessing all mothers in the Baby Care and Bright Start Nurse Home Visiting programs for smoking behaviors three months prior to pregnancy as well as during pregnancy.
• Providing cessation services via the QuitLine at no cost to the caller.

c. Plan for the Coming Year
• Provide secondhand smoke materials for the Bright Start Welcome Boxes.
• Risk assess all mothers in the Baby Care and Bright Start Nurse Home Visiting programs for smoking behaviors three months prior to pregnancy as well as during pregnancy.
• Provide cessation services via the QuitLine at no cost to the caller.
• Conduct statewide secondhand smoke public education campaign.

E. Health Status Indicators

Introduction
Ongoing review of the Health Status Indicators provides the DOH and MCH program with information on the state's population to assist in directing public health efforts. The review of the indicators is one of many pieces of ongoing data efforts that allow the MCH program to analyze and evaluate current programs and services, identify gaps in services, review goals and

objectives, and enhance collaboration with partners, if necessary. The MCH team uses this data to examine existing capacity and assist programs in aligning efforts not only within the MCH program but within the overall DOH 2010 initiative.

The South Dakota MCH surveillance system utilizes indicators such as demographics, education, income, WIC participation, health status of both mom and baby, prenatal care, pre/post health behaviors, tobacco use, and family support to drive policy and programs throughout the state. Surveillance systems used include BRFSS, Tribal PRAMS, Youth Tobacco Survey, YRBS, Medicaid, hospital discharge, birth/death certificate, Perinatal Health Risk Assessment Survey, oral health survey, and Dakota Smiles Mobile Dental Program. South Dakota uses the surveillance system data for (1) program planning, (2) implementing programs, (3) assessing program effectiveness, and (4) improving program accountability.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.9	6.6	7.0	7.0	6.5
Numerator	787	758	838	853	783
Denominator	11339	11466	11914	12253	12074
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data.

Notes - 2006
2006 South Dakota birth certificate data

Narrative:
The percent of live births weighing less than 2,500 grams shows almost a flat trend. While the percents fluctuate, none are significantly different between years.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.5	5.1	5.5	5.3	4.7
Numerator	599	574	631	624	551
Denominator	10955	11158	11524	11876	11650
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data

Notes - 2006
2006 South Dakota birth certificate data.

Narrative:
The percent of live singleton births weighing less than 2,500 grams shows a slight downward trend. While the percents fluctuate, none of the rates are significantly different between years.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.2	1.1	1.1	0.9	1.2
Numerator	139	131	135	114	139
Denominator	11339	11466	11914	12253	12074
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data

Notes - 2006
2006 South Dakota birth certificate data.

Narrative:
The percent of live births weighing less than 1,500 grams shows a slight downward trend. While the percents fluctuate, none are significantly different between years.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0.9	0.9	0.9	0.8	0.8
Numerator	102	101	108	93	91
Denominator	10955	11158	11524	11876	11650
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota birth certificate data

Notes - 2007
2007 South Dakota birth certificate data

Notes - 2006
2006 South Dakota birth certificate data.

Narrative:
The percent of live singleton births weighing less than 1,500 grams shows a slight downward trend. While the percents fluctuate, none are significantly different between years.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	25.0	18.9	13.0	13.9	11.1
Numerator	39	29	20	22	18
Denominator	155874	153650	153650	158365	161819
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2006-2008 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2006-2008 South Dakota population estimates.

Notes - 2007
2007 South Dakota birth certificate data. Rate based on 2006 South Dakota population estimates.

Notes - 2006
2006 South Dakota death certificate data. Rate based on 2005 South Dakota population estimate.

Narrative:
The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger shows a downward trend. While the rates tend to fluctuate between years, the only years that are significantly different are 2004 and 2008. The numbers used to calculate these rates are relatively small and tend to yield confidence intervals larger than larger numbers of events. The numbers used to calculate the rates for 2007 and 2008 are three-year averages to comply with the small number guideline.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	10.7	10.3	7.1	5.1	3.1
Numerator	17	16	11	8	5
Denominator	158201	155916	155916	156390	161819
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2006-2008 South Dakota death certificate data. Numerator and denominator are 3-year averages. Rates are based on 2006-2008 South Dakota population estimates.

Notes - 2007
2005-2007 South Dakota death certificate data. Numerator and denominators are 3-year averages. Rates are based on 2004-2006 South Dakota population estimates.

Notes - 2006
2004-2006 South Dakota death certificate data. Numerator and denominators are 3-year averages. Rates are based on 2003-2005 South Dakota population estimates.

Narrative:
The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes shows a downward trend. While the rates trend downward, none of the rates are significantly different that the other due to small numbers. Three-year averages were used to stabilize the rates somewhat but the small numbers still result in large confidence intervals making significant differences unlikely.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	36.2	36.4	40.6	29.6	29.0
Numerator	44	44	49	35	34
Denominator	121646	120734	120734	118168	117167
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota death certificate data. Rates are based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota death certificate data. Rate based on 2006 South Dakota population estimate.

Notes - 2006
2006 South Dakota death certificate data. Rate based on 2005 South Dakota population estimate.

Narrative:
The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years shows a slight downward trend. While the rates fluctuate, none of the rates are significantly different between years.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0	0	0	0	181.1
Numerator					293
Denominator					161799
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?					Final

Notes - 2008
2007 South Dakota Association of Healthcare Organizations hospital discharge data. Rate based on 2007 South Dakota population estimate and 2007 community hospital discharges only.

Notes - 2007
No source is available for this information.

Notes - 2006
No source is available for this information.

Narrative:
This is the first year data has been available for this indicator.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	343.2	309.1	355.4	286.9	259.7
Numerator	535	475	546	458	426
Denominator	155876	153650	153650	159647	164011
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota Department of Public Safety Accident Records data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota Department of Public Safety Accident Records data. Rate based on 2006 South Dakota population estimates.

Notes - 2006
2006 South Dakota Department of Public Safety Accident Records data. Rate based on 2005 South Dakota population estimates.

Narrative:
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children 14 years and younger shows a slight downward trend. While the rates fluctuate, only the 2007 and 2008 rates are significantly different from 2004 and 2006.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1,819.2	1,717.0	1,633.3	1,553.7	1,485.1
Numerator	2213	2073	1972	1836	1740
Denominator	121646	120734	120734	118168	117167
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota Department of Public Safety Accident Records data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota Department of Public Safety Accident Records data. Rate based on 2006 South Dakota population estimates.

Notes - 2006
2006 South Dakota Department of Public Safety Accident Records data. Rate based on 2005 South Dakota population estimates.

Narrative:
The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years shows a slight downward trend. While the rates fluctuate between years, the 2007 and 2008 rates are significantly different from the rates for the years 2004 and 2005 while only 2008 is significantly different than 2006.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	25.0	26.1	26.2	23.7	28.7
Numerator	729	753	754	663	800
Denominator	29128	28827	28827	27957	27901
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota Department of Health communicable disease data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota Department of Health communicable disease data. Rate based on 2006 South Dakota population estimate.

Notes - 2006
2006 South Dakota Department of Health communicable disease data. Rate based on 2005 South Dakota population estimate.

Narrative:
The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia shows a slight upward trend. While the rates tend to fluctuate between years, the only years that are significantly different are 2007 and 2008. Further monitoring of future data should reveal the direction the measure is taking.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	8.3	8.7	8.5	9.3	10.7
Numerator	1055	1102	1083	1149	1330
Denominator	127419	127289	127289	123957	124611
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
2008 South Dakota Department of Health communicable disease data. Rate based on 2008 South Dakota population estimate.

Notes - 2007
2007 South Dakota Department of Health communicable disease data. Rate based on 2006 South Dakota population estimate.

Notes - 2006
2006 South Dakota Department of Health communicable disease data. Rate based on 2005 South Dakota population estimate.

Narrative:
The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia shows a slight upward trend. While the rates tend to fluctuate between years, the only year that is significantly different from other years is 2008.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	12368	9957	183	1645	116	8	459	0
Children 1 through 4	46198	36139	1025	6914	429	28	1663	0
Children 5 through 9	52511	41830	1136	7286	527	54	1678	0
Children 10 through 14	52934	42890	988	7082	443	32	1499	0
Children 15 through 19	57450	47648	818	7357	311	30	1286	0
Children 20 through 24	59717	51674	772	5979	451	29	812	0
Children 0 through 24	281178	230138	4922	36263	2277	181	7397	0

Notes - 2010

Narrative:
Based on the Census Bureau population estimates for 2008, the 0-24 population racial composition consist of 81.8 percent white, 12.9 percent American Indian and 2.7 percent to the remaining minorities of which 2.6 percent were allocated to the multiple race classification. The estimates for those age 24 years and younger have increased 1.2 percent between 2006 and 2008, the white estimate increased 0.8 percent and the American Indian decreased 1.2 percent from 2006. The American Indian are the minority race of this age group that decreased in numbers.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	11822	546	0
Children 1 through 4	43357	2841	0
Children 5 through 9	49554	2957	0
Children 10 through 14	50851	2083	0
Children 15 through 19	55808	1642	0
Children 20 through 24	58277	1440	0
Children 0 through 24	269669	11509	0

Notes - 2010

Narrative:
The Hispanic population for this age group has also increased 0.1 percent from 2006 to 2008. The ages 0-9 increased in numbers by 4.9 percent between the years 2006 and 2008 while the ages 10-24 decreased in numbers by 1.1 percent.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	14	4	0	9	0	0	1	0
Women 15 through 17	345	151	5	158	2	0	27	2
Women 18 through 19	772	459	7	266	3	0	36	1
Women 20 through 34	9789	7848	154	1431	104	5	234	13
Women 35 or older	1154	970	19	128	31	0	4	2
Women of all	12074	9432	185	1992	140	5	302	18

ages								

Notes - 2010

Narrative:
The overall number of births decreased 1.5 percent from 2007 to 2008. The only categories showing increases were Asian 8.5 percent, the multi race category 7.9 percent and other/unknown 12.5 percent. The categories showing decreases were white 1.5 percent, Black 4.1 percent, American Indian 3.1 percent and Hawaiian 44.4 percent. Non-Hispanic births decreased by 1.3 percent. The births in the two youngest age groups increased; 55.6 percent in the <15 group and 3.3 percent in the 15-17 group, while the other age groups decreased in numbers by 9.7 percent in the 18-19 age group, 1.0 percent in the 20-34 age group and 0.9 percent in the 35+ age group.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	13	1	0
Women 15 through 17	315	30	0
Women 18 through 19	716	56	0
Women 20 through 34	9448	341	0
Women 35 or older	1121	32	1
Women of all ages	11613	460	1

Notes - 2010

Narrative:
Hispanic births decreased by 2.3 percent.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	100	60	2	29	0	0	9	0
Children 1 through 4	13	8	0	4	0	0	1	0
Children 5 through 9	5	4	0	1	0	0	0	0
Children 10 through 14	8	4	0	2	0	0	2	0
Children 15	47	28	0	16	0	0	3	0

through 19								
Children 20 through 24	62	43	1	16	0	0	2	0
Children 0 through 24	235	147	3	68	0	0	17	0

Notes - 2010

Narrative:
The overall number of deaths among those 24 years old and younger increased 11.4 percent from 2007 to 2008. All but one of the race categories increased in numbers. Those races with increasing numbers were white 7.3 percent and American Indian 13.4 percent. The other minority numbers were too small to provide meaningful statistics. The Non-Hispanic deaths increased 12.3 percent for this age group from 2007 to 2008.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	93	6	1
Children 1 through 4	13	0	0
Children 5 through 9	5	0	0
Children 10 through 14	8	0	0
Children 15 through 19	47	0	0
Children 20 through 24	62	0	0
Children 0 through 24	228	6	1

Notes - 2010

Narrative:
Numbers for deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity are too small to provide meaningful statistics.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	221461	178464	4150	30284	1826	152	6585	0	2008
Percent in household headed by	20.9	17.0	39.9	41.4	0.0	0.0	0.0	30.0	2008

single parent									
Percent in TANF (Grant) families	2.4	0.7	0.0	13.2	0.0	0.0	0.0	1.7	2008
Number enrolled in Medicaid	74603	37857	3358	30074	0	0	0	3314	2008
Number enrolled in SCHIP	18463	12727	618	4147	0	0	0	971	2008
Number living in foster home care	2811	936	166	1682	14	8	0	5	2008
Number enrolled in food stamp program	31572	15052	948	13753	150	37	1632	0	2008
Number enrolled in WIC	28680	18390	870	7802	172	119	1311	16	2008
Rate (per 100,000) of juvenile crime arrests	3896.6	3002.9	7444.4	8522.5	3592.1	0.0	0.0	5220.9	2008
Percentage of high school drop-outs (grade 9 through 12)	4.3	2.3	5.9	16.0	3.3	0.0	0.0	7.5	2008

Notes - 2010
2008 population estimate

2000 Census

SFY2008

FFY2008

FFY2008

July 2008

SFY2008

SFY2008

2007/2008 school year

SFY2008

Narrative:
The data used to prepare this indicator are from various agencies many outside the DOH. These agencies collected data in ways inconsistent with one another. Some agencies do not update unknown data after the records are initially entered and therefore have large unknown categories.

When this data is used to calculate population based rates, unreliable statistics are generated. Many of the agencies collect the race information differently than the DOH and some do not collect ethnic data. Therefore the data provided for this indicator are difficult to compare between lines due to the differences in collection methods and are best used for comparing the same lines to previous years data.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	211392	10069	0	2008
Percent in household headed by single parent	20.0	30.8	0.0	2008
Percent in TANF (Grant) families	0.0	0.0	2.4	2008
Number enrolled in Medicaid	72080	2523	0	2008
Number enrolled in SCHIP	17756	707	0	2008
Number living in foster home care	2595	216	0	2008
Number enrolled in food stamp program	30826	746	0	2008
Number enrolled in WIC	26589	2075	16	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	3896.6	2008
Percentage of high school drop-outs (grade 9 through 12)	4.3	7.5	0.0	2008

Notes - 2010
2008 population estimate

2000 Census

SFY2008

FFY2008

FFY2008

July 2008

SFY2008

SFY2008

2007/2008 school year

SFY2008

Narrative:
The data used to prepare this indicator are from various agencies many outside the DOH. These agencies collected data in ways inconsistent with one another. Some agencies do not update

unknown data after the records are initially entered and therefore have large unknown categories. When this data is used to calculate population based rates, unreliable statistics are generated. Many of the agencies collect the race information differently than the DOH and some do not collect ethnic data. Therefore the data provided for this indicator are difficult to compare between lines due to the differences in collection methods and are best used for comparing the same lines to previous years data. Minority numbers are too small to provide meaningful statistics.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	77464
Living in urban areas	112862
Living in rural areas	71056
Living in frontier areas	43563
Total - all children 0 through 19	227481

Notes - 2010

Narrative:
The data used in this indicator are 2000 census data. This is the most recent data available with the level of detail needed.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	727425.0
Percent Below: 50% of poverty	5.8
100% of poverty	13.2
200% of poverty	33.1

Notes - 2010

Narrative:
The data used in this indicator are 2000 census data. This is the most recent data available with the level of detail needed.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	198003.0
Percent Below: 50% of poverty	8.1
100% of poverty	17.2
200% of poverty	41.1

Notes - 2010

Narrative:
The data used in this indicator are 2000 census data. This is the most recent data available with the level of detail needed.

F. Other Program Activities

Preventive/Primary Care Services for Pregnant Women, Mothers and Infants -- MCH perinatal program staff at the state, regional, and community level provide services, offer technical assistance, and partner with other agencies to improve the health of pregnant women, mothers, and infants and impact pregnancy outcomes. Staff in the community provide direct case management and education services, link clients with appropriate resources, and collaborate with public and private partners to assure access to services. Nurse home visiting programs modeled after the David Olds model are available in Rapid City, Sioux Falls, and Pine Ridge. Quality of services is assured through formalized activities at the state and local level. Client education materials are made available for both agency staff and private partners to utilize in the provision of services to this population. Training for professionals is provided directly or through collaboration with other agencies.

Preventive/Primary Care Services for Children and Adolescents -- DOH staff at the state, regional, and community level provide services, offer technical assistance, and partner with other agencies to improve the health of children and adolescents. Staff in the community provide developmental/social-emotional screening, immunizations, school screenings, health fairs, health education for school-age children, and parent education and participate locally on various advisory groups such as child protection teams, coordinated school health councils, interagency teams, etc. They share information and resources to facilitate referral to programs (i.e., SCHIP, food stamps, and heating assistance) and work with state agencies, organizations, communities, and partners to provide technical assistance to promote MCH programs. Program staff also participate on several workgroups facilitated by other state agencies. There is a memorandum of understanding between WIC and OCHS that enhances public health services of both WIC and MCH.

Services for CSHCN -- State CSHCN staff participate in numerous activities to enhance the capacity of the health and related service systems to identify and refer CSHCN in a timely and efficient manner. Networking and public education activities are ongoing by program staff. These activities also provide opportunities to discuss service delivery and other issues impacting CSHCN. MCH funds assist in the provision of respite care services for CSHCN, with staff also assisting in the application process as appropriate. The CSHCN program director also represents the program on the State Interagency Coordinating Council for Birth to Three as well as various other workgroups and committees at the state level.

G. Technical Assistance

The MCH program is committed to assuring that all MCH populations in the state receive the highest quality care and have optimal health. The MCH program is requesting technical assistance in examining the rates of women who report not gaining the ideal weight during pregnancy. In 2007, 44.8% of pregnant women reported gaining more than ideal weight during pregnancy while 17.3% reported gaining less than the ideal weight. Both affect pregnancy complications and birth outcomes.

V. Budget Narrative

A. Expenditures

Activities performed by MCH program and field staff that provide services funded by the MCH block grant are accounted for by a daily time study. The time study includes funding codes that reflect the population being served (i.e., child/adolescent, pregnant women, mothers and infants, and CSHCN). Function codes determine if the service was direct, enabling, population-based, or infrastructure. Examples of this are developmental screening, immunization administration, travel to provide services, training, networking, quality assurance, and case management.

The budget amounts reflect anticipated activities of program and field staff but actual expenditures can vary based on the state economy and public health events (i.e., outbreaks, natural disasters). South Dakota law prohibits deficit spending so the Governor and state Legislature control the spending of general funds that in turn affect dollars that are available for MCH block grant match.

B. Budget

MCH block grant funds have historically been used to address DOH priorities as outlined in the needs assessment and annual plan of the MCH block grant application. The comprehensive needs assessment process assists the DOH in setting priorities for resource allocation. The amount of funding allocated to MCH services is determined as part of the state budget process that includes development of the budget by the DOH, interim approval by the Bureau of Finance and Management (BFM) and Governor's Office, and final approval by the state Legislature.

The budget outlines areas for which Title V funds will be allocated. Development of the budget complies with the "30-30" requirement for primary and preventive care and special health care needs for children and adolescents and is consistent with the requirements to limit administrative costs to no more than ten percent. The DOH maintains the overall level of funds for MCH at the level established in FFY 1989.

Appropriation of general funds for MCH state match is at the discretion of the Legislature, Governor's Office, and DOH. State match funding sources are state funds (including general funds appropriate by the Legislature), local match, program income, and other sources (i.e., Vital Records). No foundation or other private funding is currently available or utilized. The level of funds utilized from each match source varies from one year to the next based on availability of funds and the state's allocation process. Increasing inflationary costs have depleted revenue reserves within the DOH and the state as a whole and required shifts in match fund sources.

Budget development is subject to rules and requirements set by BFM dictating both the process and content of the budget, including availability of funds and limitations on authorization levels. State MCH programs were first required to use the current format of reporting budgets and expenditures (including levels of the pyramid) in FFY 1999. Since that time, South Dakota has been refining the budget development and expenditure process to meet both state and federal rules and requirements. The DOH continues to work to move to accounting programs that more easily reflect population group and pyramid level reporting requirements. From FY08 to FY09, OFH gained over $800,000 in WIC funding. This increase occurred to support the increased caseload and cost to provide services. SSDI funding remained level while Abstinence, Title X, and other CDC funding saw losses of funding. These loses have forced programs to create efficiencies and look at other ways of delivering services to the populations these dollars serve.

Direct Health Services: A portion of the MCH block grant has traditionally been allocated to health service delivery (state-employed CHNs and nutritionists/dietitians) based on DOH time study data. For Alliance sites, services are contracted out to private agencies with DOH staff

providing technical assistance to communities and maintaining its role of assessment, assurance, and evaluation. DOH time study data tracks actual time spent delivering MCH services and activities. CHNs, dietitians, and nutritionists provide MCH services statewide to assure a local delivery system of quality public health services. The budget reflects the projected allocations to assure provision of postpartum/MCH home visits and family planning services. This allocation of funds enables a system of service delivery to assure essential health care services are available in rural areas of the state. The DOH continues to move to reduction of direct health care services when appropriate.

Enabling Services: MCH block grant funds support activities to enhance access to care and assist consumers receive needed services (i.e., Bright Start toll-free number, care coordination for CSHCN and their families, translation, respite care, and parent support activities).

Population-Based Services: Allocations in this area support newborn metabolic screening, coordinated school health, injury prevention, oral health, school screenings, community immunization coalitions, immunizations, outreach and public education, risk assessment of pregnant women, child health conferences/developmental screenings, and breastfeeding activities.

Infrastructure Building Services: Allocations in this area provide funding to support program staff, benefits, travel, operating, training, supplies, materials, capital outlay, and contractual services. Activities funded include needs assessment, community coordination/collaboration, community assistance, quality assurance, policy development, program planning and evaluation, interagency collaboration, training, technical assistance to field staff and public/private partners, and data collection and analysis.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.